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1994

Illinois Register

Rules of Governmental Agencies

Volume 18, Issue 10 — March 11, 1994

Pages 3164-3801

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published by
George H. Ryan
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INTRODUCTION

The Illinois Register is the official state document for publishing public notice of rulemaking activity by State governmental agencies. The table of contents is arranged categorically by rulemaking activity and alphabetically by agency within each category. Rulemaking activity consists of proposed or adopted new rules or amendments to or repealers of existing rules, including those by emergency or peremptory action.

The *Register* also contains Executive Orders and Proclamations issued by the Governor, notices of public information required by State statute, and activities (meeting agendas, Statements of Objection or Recommendation, etc.) of the Joint Committee on Administrative Rules (JCAR), a legislative oversight committee which monitors the rulemaking activities of State agencies. In addition, the *Register* contains a Cumulative Index listing alphabetically by agency the Parts (sets of rules) on which rulemaking activity has occurred in the current *Register* volume and a Sections Affected Index listing, by Title of the *Illinois Administrative Code*, each Section (including supplementary material) of a Part on which rulemaking activity has occurred in the current volume. Both indices are action coded and are designed to aid the public in monitoring rules.

The *Register* will serve as the update to the *Illinois Administrative Code*, a compilation of the rules of State agencies. The most recent edition of the *Code* along with the *Register* comprise the most current accounting of the State agencies' rules.

The *Illinois Register* is the property of the State of Illinois, granted by the authority of the Illinois Administrative Procedure Act [5 ILCS 100/1-1 et seq.].

REGISTER PUBLICATION SCHEDULE 1994

Material Rec'd after 12:00 p.m. on:	And before 12:00 p.m. on:	Will be in Issue #:	Published on:	Material Rec'd after 12:00 p.m. on:	And before 12:00 p.m. on:	Will be in Issue #:	Published on:
Dec. 21, 1993	Dec. 28, 1993	1	Jan. 7, 1994	June 28, 1994	July 5, 1994	28	July 15, 1994
Dec. 28, 1993	Jan. 4, 1994	2	Jan. 14, 1994	July 5, 1994	July 12, 1994	29	July 22, 1994
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Please note: When the Register deadline falls on a State holiday, the deadline becomes 4:30 p.m. on Monday (the day before).

DEPARTMENT OF AGRICULTURE

NOTICE OF PROPOSED AMENDMENTS

- 1) Heading of Part: Illinois State Fair and DuQuoin State Fair, Non-Fair Space Rental and the General Operation of the State Fairgrounds

- 2) Code Citation: 8 Ill. Adm. Code 270

<u>Section Numbers:</u>	<u>Proposed Action:</u>
270.10	Amended
270.15	Amended
270.20	Amended
270.35	Amended
270.40	Amended
270.50	Amended
270.70	Amended
270.75	Amended
270.85	Amended
270.90	Amended
270.95	Amended
270.130	Amended
270.135	Amended
270.140	Amended
270.150	Amended
270.165	Amended
270.170	Amended
270.180	Amended
270.190	Amended
270.205	Amended
270.210	Amended
270.221	New Section
270.230	Amended
270.235	Amended
270.240	Amended
270.245	Amended
270.261	Amended
270.280	Amended
270.320	Amended
270.365	Amended
270.371	New Section
270.395	Amended
270.480	Amended
270.510	Amended
270.540	Amended
270.625	Amended
270.685	Amended

- 4) Statutory Authority: The State Fair Act (Ill. Rev. Stat. 1991, ch. 127, par. 1701 et seq.) [20 ILCS 210], as amended by P.A. 88-5, effective June 8, 1993; Section 40.14 and Section 16 of the Civil Administrative Code of Illinois

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NOTICE OF PROPOSED AMENDMENTS

(Ill. Rev. Stat. 1991, ch. 127, pars. 16 and 40.14) [20 ILCS 5/16 and 205/40.14].

- 5) A Complete Description of the Subjects and Issues Involved: Citations to the Illinois Revised Statutes have been updated, and citations to the Illinois Compiled Statutes have been added.

In Section 270.10, a new definition was added and other definitions were clarified. In Section 270.15, a clarification was added to allow the Department the flexibility of shortening the length of the fair if necessary.

In Section 270.35, the intent of this amendment is to allow more flexibility in recruiting concessioners/exhibitors to the State Fair which will generate substantial dollar payments and improve the appearance of the fairgrounds. This change is extremely important due to the implementation of the State Fair Fund. In Section 270.40, this change is to facilitate earlier review of applications for new concessioners/exhibitors for the State Fair.

In Section 270.75, the amendment clarifies the concessioner's right to assign the contract to a family member while still retaining the prohibition to the assignment of the contract to a third party. Section 270.85 clarifies the conditions under which a concessioner/exhibitor may be removed from the fairgrounds and removes the grant of privilege. The language concerning approval in writing by the State Fire Marshal has been deleted in Section 270.95. The State Fire Marshal routinely inspects all installations but does not provide approval in writing.

Section 270.130 provides additional clarification of Department policy. Section 270.135 provides for accelerated payment of space rental fees and amends the method of payment. The amendment in Section 270.140 is an effort to accommodate reasonable hours of operation for commercial concessioners/exhibitors. In Section 270.150, it has been the Department's experience that negotiating contracts in certain areas such as in the leasing of facilities during the fair that the 15% percentage rate may not be economically feasible.

Section 270.170 clarifies the height requirements for inside exhibits. Section 270.180 clarifies current policy. In an effort to enhance the appearance of the State Fairgrounds, an amendment to Section 270.210 clarifies where a

DEPARTMENT OF AGRICULTURE

NOTICE OF PROPOSED AMENDMENTS

concessioner's/exhibitor's trailer can be stored during the Springfield State Fair. Section 270.221 is a new section defining the State Fair Manager's authority to close concessions and limit operations in emergency circumstances.

Sections 270.235, 270.240, and 270.245 have been amended due to recent funding problems by the General Assembly that necessitate the negotiation of contracts beyond the July 1 deadline.

Section 270.50 amends the method for reassigning space. Section 270.70 amends the procedure for requesting space for persons distributing information and/or soliciting contributions in the exercise of their constitutional freedoms. Section 270.371 is proposed new language to implement Public Act #88-5 which allows for the leasing of facilities during the State Fair.

Section 270.510 is amended in an effort to allow the flexibility to book long term multiple year events at the State Fairgrounds which could substantially enhance the revenue of the Illinois State Fair.

6) Will this proposed rule replace an emergency rule in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this proposed amendment contain incorporations by reference? No

9) Are there any other amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: Rule does not affect units of local governments.

11) Time, Place and Manner in which interested persons can comment on this proposed rulemaking:
A 45-day written comment period will be granted for receiving comments from the public. This comment period will begin on the day the notice of rulemaking appears in the Illinois Register. Comments should be sent to the attention of Debbie Wakefield, Department of Agriculture, State Fairgrounds, P.O. Box 19281, Springfield, Illinois 62794-9281.

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses affected: None

B) Reporting, bookkeeping or other procedures required for

DEPARTMENT OF AGRICULTURE

NOTICE OF PROPOSED AMENDMENTS

compliance: None

C) Types of professional skills necessary for compliance: None

The full text of the Proposed Amendments begins on the next page:

DEPARTMENT OF AGRICULTURE

NOTICE OF PROPOSED AMENDMENT(S)

TITLE 8: AGRICULTURE AND ANIMALS
CHAPTER I: DEPARTMENT OF AGRICULTURE
SUBCHAPTER J: FAIRS

PART 270

ILLINOIS STATE FAIR AND DUQUOIN STATE FAIR,
NON-FAIR SPACE RENTAL AND THE GENERAL
OPERATION OF THE STATE FAIRGROUNDS

SUBPART A: DEFINITIONS: POLICY: VIOLATION

Section

270.10	Definitions
270.15	Policy
270.20	Violation of Rules; Administrative Hearings

SUBPART B: CONCESSIONS AND EXHIBITS AT THE STATE FAIR

Section

270.25	Categories of Exhibits
270.30	Privilege to Operate a Concession or Exhibit
270.35	Application for Reassignment of Space
270.40	New Applications for Space Rental
270.45	Substitute Locations or Discontinuance of Contracts
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270.55	Number of Stands Permitted
270.60	Policy Governing Exhibits/Concessions and Approval to Conduct Business
270.65	Policy of Permitting Space Without Monetary Charge
270.70	Exercising Constitutional Freedoms
270.75	Assignment of Contracts
270.80	Inspection of Premises
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270.105	Measuring Space
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270.120	Display of Exhibit or Concession Number
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270.175	Posting Food Prices
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270.190	Food and/or Drink Service Operations
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270.200	Security
270.205	Liability
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270.215	Failure to Abide by Rules or Contract Provisions
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270.221	Emergency Closing

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Section

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270.230	State Fair Colt Stakes Races
270.235	Review Futurity Races
270.240	Illinois Trotting and Pacing Colt Races
270.245	Quarter Horse Races

SUBPART D: PREMIUMS AND RULES GOVERNING EXHIBITS OR EVENTS

Section

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270.255	Premium Books
270.260	Payment of Premiums
270.261	Land of Lincoln Breeders Awards for Purebred or Registered Livestock

SUBPART E: JUDGES: STATE FAIR

Section

270.265	Professional and Artistic Contracts
270.270	Judge's Salary
270.275	Selection of Judges

SUBPART F: CERTIFICATES OF AWARD: STATE FAIR

Section

270.280	Certificates, Ribbons and Trophies
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270.665	Quarantine Provisions
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270.675	General Misconduct
270.680	Track Usage
270.685	Restrictions on Barn Use
270.690	

AUTHORITY: Implementing and authorized by the State Fair Act (Ill. Rev. Stat. 1985 1991, ch. 127, par. 1701 et seq.) [20 ILCS 210], as amended by P.A. 88-5, effective June 8, 1993; Implementing Section 40.14 and authorized by Section 16 of the Civil Administrative Code of Illinois (Ill. Rev. Stat. 1985 1991, ch. 127, pars. 16 and 40.14) [20 ILCS 5/16 and 205/40.14].

SOURCE: Adopted at 4 Ill. Reg. 25, p. 34, effective June 11, 1980; amended at 5 Ill. Reg. 1332, effective January 29, 1981; codified at 5 Ill. Reg. 10532; amended at 6 Ill. Reg. 8958, effective July 9, 1982; amended at 8 Ill. Reg. 6103, effective April 25, 1984; emergency amendments at 10 Ill. Reg. 13370, effective July 28, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 14282, effective August 20, 1986; amended at 10 Ill. Reg. 20468, effective November 26, 1986; amended at 11 Ill. Reg. 2228, effective January 20, 1987; amended at 15 Ill. Reg. 455, effective January 2, 1991; amended at _____ Ill. Reg. _____, effective _____.

NOTE: CAPITALIZATION DENOTES STATUTORY LANGUAGE.

SUBPART A: DEFINITIONS: POLICY: VIOLATION

Section 270.10 Definitions

Unless the context otherwise requires, the terms shall have the following meanings:

"Authorized vehicle" is an on-road or off-road vehicle operated by the Department of Agriculture.

DEPARTMENT OF AGRICULTURE

NOTICE OF PROPOSED AMENDMENT(S)

"Concessionaire/Commercial Exhibitor" means any person ~~who makes available for the public goods or services selling directly to the public or taking orders for future sales pursuant to an annual space rental contract.~~

"Division" means the Division of Fairs and Horse Racing, Department of Agriculture, State Fairgrounds, Springfield, Illinois 62706.

"Exhibitor" means any person who displays his/her goods, displays his/her person, or distributes information and is not engaged in sales pursuant to an annual space rental contract, or participates in programs offered by the Department.

"Person" means any individual, partnership, corporation, association, governmental or religious entity.

"Space Rental Contract" means a written contract entered into between the person(s) desiring to put on an exhibit or operate a concession and the Department.

"Space Rental Office" means the office in charge of space rental, Division of Fairs and Horse Racing, Department of Agriculture, State Fairgrounds, Springfield, Illinois 62706 or the office in charge of space rental for the DuQuoin State Fair, Division of Fairs and Horse Racing, Department of Agriculture, Fairgrounds, DuQuoin, Illinois 62832.

"Special Agreement" means a multiple year or single year lease subject to a negotiated rate. This type of agreement would include persons building permanent structures, multiple year off season rentals, single or multiple year fair-time leases, etc.

"State Fair" means the annual event that is held at Springfield or the annual event that is held at DuQuoin for the purposes as set forth in Section 270.15.

"State Fairgrounds" mean all the land and water areas, including all buildings and facilities located thereon, known as the State Fairgrounds at Springfield or DuQuoin.

"Superintendent of the Division of Fairs and Horse Racing" means the Superintendent of the Division of Fairs and Horse Racing, Department of Agriculture, State Fairgrounds, Springfield, Illinois 62706.

(Source: Amended at _____ Ill. Reg. _____, effective _____)

DEPARTMENT OF AGRICULTURE

NOTICE OF PROPOSED AMENDMENT(S)

_____)

Section 270.15 Policy

- a) IT IS THE POLICY OF THIS STATE THAT THE DEPARTMENT OPERATE THE ILLINOIS STATE FAIR AS A SHOWCASE FOR THE NATION AND WORLD TO VIEW ILLINOIS AGRICULTURE, TO PROVIDE FOR INDUSTRIAL, CULTURAL, EDUCATIONAL, TRADE AND SCIENTIFIC EXHIBITS, TO PROMOTE THE SPORT OF HORSE RACING AND OTHER COMPETITIVE SPORTS AND FOR THE ENTERTAINMENT AND ENJOYMENT OF THE PEOPLE OF THE STATE OF ILLINOIS (Section 3 of the State Fair Act, Ill. Rev. Stat. 1995, ch. 127, par. 1703) [20 ILCS 210/31]. The annual Illinois State Fair, located at Springfield, will be held commencing ~~on~~ not earlier than the Thursday that is twenty-five days prior to Labor Day. The DuQuoin State Fair will be held commencing ~~on~~ not earlier than the Saturday that is nine days prior to Labor Day.

- b) The policy governing the general operation of the Illinois State Fair and the State Fairgrounds at Springfield shall be applicable to the general operation of the DuQuoin State Fair and the State Fairgrounds at DuQuoin.

(Source: Amended at _____ Ill. Reg. _____, effective _____)

Section 270.20 Violation of Rules; Administrative Hearings

- a) "VENDORS, CONCESSIONAIRES, EXHIBITORS AND PERSONS RENTING SPACE OR USING FACILITIES AT THE STATE FAIRGROUNDS WHO VIOLATE THE RULES AND REGULATIONS ADOPTED BY THE DEPARTMENT TO GOVERN THE OPERATION OF THESE ACTIVITIES SHALL BE GUILTY OF A BUSINESS OFFENSE." (Section 13 of the State Fair Act (Ill. Rev. Stat. 1993, ch. 127, par. 1713) [20 ILCS 210/13].

- b) All decisions and actions of the Department are subject to the Illinois Administrative Procedure Act (Ill. Rev. Stat. 1991, ch. 127, par. 1001-1 et seq.) 5 ILCS 100/11 and the Department's Administrative Rules (8 Ill. Adm. Code 1) which pertains to administrative hearings, petitions, proceedings, contested cases, declaratory rulings and availability of Department files for public access. Administrative hearings are governed by the Illinois Administrative Procedure Act and Subpart B of the Department's Administrative Rules.

DEPARTMENT OF AGRICULTURE

NOTICE OF PROPOSED AMENDMENT(S)

(Source: Amended at 18 Ill. Reg. _____, effective _____)

Section 270.35 Application for Reassignment of Space

Application for reassignment of space will be provided in the following manner:

- a) Following the close of the most recent State Fair, all concessionaires/exhibitors will be evaluated with regard to performance (i.e., payment of fees, violation of public health rules (if applicable), appearance of concession/exhibit, revenue generated, compliance with State Fair rules (subparts A through I of this part, as applicable), and any formal written complaints from the public arising out of the performance of activities on the fairgrounds.

- a+b) Those concessionaires/exhibitors that perform in an acceptable manner based on the criteria described in this section shall be mailed an application to reapply for reassignment or relocation of space. An application will be mailed by the Space Rental Office to the ~~the~~ previous year's concessionaire/exhibitor at the address on file with the Department not later than January 1 preceding ~~that~~ the next year's State Fair. It shall be the responsibility of each concessionaire/exhibitor desiring reassignment or relocation of space to return ~~their~~ its application to the Space Rental Office no later than March 1. Failure to receive the application for reassignment or relocation of space shall not relieve the concessionaire/exhibitor from ~~his/her~~ its responsibility to request reassignment or relocation of space prior to the March 1 deadline.

- b+c) After evaluating the reapplication ~~reapplications~~ for space submitted pursuant to subsection (a) of this section, ~~by concessionaires/exhibitors of the most recent State Fair~~ and spaces have been assigned by the Director or his a designated representative, all new applications for space rental will be evaluated. ~~in evaluating reapplications for space, the Department shall consider the previous performance history of the applicant with the State Fair (i.e., payment of fees, violation of public health rules (if applicable), compliance with State Fair rules (Subparts A through I of this part, as applicable), and complaints from the public arising out of activities on the fairgrounds).~~

DEPARTMENT OF AGRICULTURE

NOTICE OF PROPOSED AMENDMENT(S)

(Source: Amended at ___ Ill. Reg. ___, effective ___)

Section 270.40 New Applications for Space Rental

~~A new application~~ New applications for space rental to operate either a concession or exhibit shall be filed annually with the Division. ~~The period for filing new applications shall be no earlier than September 1 and shall be accepted no later than April 1 June 30. Consideration of new applications for space rental will be given after March February 1 at the close of the reapplication period. These new~~ New applications for space rental shall be processed in the following manner:

a) All new applications for space rental shall be sent to the Division and shall be accompanied by a photograph or drawing of the concession/exhibit stand. If the proposed concession/exhibit should differ significantly from the photograph or drawing that was submitted with the application, the Department shall reserve reserves the right to reconsider the application for space. Several factors that would affect the approval of the application would be physical limitations and restrictions, the general appearance of the structure, possible interference with existing structures, power sources, sewage, and water service.

b) All new applications for space rental will be classified by the Department as a concession or as to the type of concession/exhibit that would will be operated.

c) ~~No application~~ All new applications for space rental will be processed until all reassignments considered after all reapplications and relocations have been completed in accordance with pursuant to Section 270.35.

d) All new applications for space rental will be considered on a first-come basis in accordance with the date stamp of the Department indicating receipt. Granting of the privilege to rent space to operate a concession/exhibit shall be based on the following criteria:

- 1) The Department at all times shall attempt to promote the current theme of the State Fair;
- 2) the current number of similar concessions/exhibits of various classifications of exhibits already operating at the State Fair on the grounds;

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- 3) the aesthetic value and overall appearance of the fairgrounds to the general public, including stand design structure the general appearance of the concession/exhibit, revenue potential to the Department, stand design, structure, sanitation requirements and physical constraints.

(Source: Amended at ___ Ill. Reg. ___, effective ___)

Section 270.50 Reassignment of Space by Department

After a site is contracted for, there shall not be any change in location unless such change is necessary in accordance with Section 270.45 or this rule. In the event the same space is sold to two or more concessionaires/exhibitors, the space shall be reassigned in accordance with the receipt of the application as disclosed by the Department's date stamp. In the event of simultaneous dates, reassignment shall be by lottery. Said lottery shall be conducted by the Director or a duly authorized designated representative.

(Source: Amended at ___ Ill. Reg. ___, effective ___)

Section 270.70 Exercising Constitutional Freedoms

At the request of any Any person desiring to distribute information, literature and/or solicit contributions on the fairgrounds in the exercise of their constitutional freedoms, the Department shall specify designate an area or areas in which the proposed activities may be conducted. All activities shall be conducted only from within, and not from without, a booth which shall be located in the area or areas as designated by the Director, or a designated representative, for such purpose. In the event two or more persons seek to exercise constitutional freedoms at the same time, the Director shall apportion the available area or areas between or among them all on as equitable a basis as possible. The Director may move such permitted activities from one area to another and among the different areas upon reasonable written notice to the applicant when in the judgment of the Director such move or moves are necessary to the efficient and effective operation of the State Fair. All persons requesting such space shall apply for space pursuant to Sections 270.35 and Section 270.40. Privilege granted pursuant to this section shall be provided at no charge. The provisions of Section 270.115 relative to broadcasting devices shall pertain to all persons exercising their constitutional freedoms.

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(Source: Amended at ___ Ill. Reg. ___, effective ___)

Section 270.75 Assignment of Contracts

State Fair exhibit or concession contracts or any portion thereof shall not be assigned, interest therein hypothecated or otherwise disposed of without the written consent of the Department. Obligations provided for in said contracts, including payments for space, electric service, or gas shall remain the obligation of initial lessee, irrespective of approved subleasing or assignment otherwise provided. It is the Department's policy that contracts shall not be assigned unless death, injury or sickness of the original lessee makes an assignment necessary in order to perform the provisions of the lease for that year's fair. Approved subcontracting does not transfer any rights to reapportionment to the subcontractor, and it is the policy of the Department that subcontracting is only valid for the current year's fair.

(Source: Amended at ___ Ill. Reg. ___, effective ___)

Section 270.85 Removal or Denial of Acceptance

a) The Department reserves the right to deny admittance of or to remove from the State Fairgrounds, Fairgrounds any person, exhibit, animal, or concession, or show that: may be falsely entered or represented, or to deny acceptance of or remove from the State Fairgrounds any exhibit, animal, concession or show, or to remove any sign, banner, display material or advertising matter if such exhibit/display is contrary to law, or in violation of the Department's valid interest in providing for the health, safety and/or protection of the fairgoing public, pandering shall be prohibited as provided for in Article 11 of the Criminal Code of 1961 (Ill. Rev. Stat. 1983, ch. 38, par. 11-16 et seq.). Any person or persons objecting to the decision of the Department pursuant to this rule shall avail themselves of the Department's administrative procedure for contested cases if they desire to question the decision (see Section 270.20(b)). In the event that the Director or his duly authorized representative determines that immediate action is set forth above must be undertaken to protect the public from substantial injury and irreparable harm, a hearing must be scheduled for the benefit of the person against whom the action is taken, and conducted, if requested, within 15 hours from the time the removal notice or denial is

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given-

1) is falsely entered or represented to the Department.

2) is in violation of its exhibitor, concessionaire, space rental, or any other type of contract entered into with the Department for performance at the State Fair.

3) is detrimental to the health, safety, or welfare of the fair-going public.

b) The Department also reserves the right to remove any sign, banner, display or advertising material if such material is in violation of the Department's public policy stated in the Ill. Rev. Stat. 1991, ch. 127, par. 1703 [20 ILCS 210/31].

c) In the event that the Director or a duly authorized representative determines that any person, exhibit, animal, concession or show should be removed from or denied acceptance to the State Fairgrounds, that decision shall be effective immediately.

d) Any person or persons objecting to the decision of the Department pursuant to this section may file a petition according to the Department's administrative procedure [8 Ill. Adm. Code 1.50(b)]. If the Director's response pursuant to 8 Ill. Adm. Code 1.265 is that administrative proceedings should be initiated in regard to the petition, said administrative hearing shall be held within 15 hours from the time the removal notice or denial is given.

(Source: Amended at ___ Ill. Reg. ___, effective ___)

Section 270.90 Concessions and Exhibits Prohibited

No roving concessions or exhibits shall be permitted. No shows or exhibitions featuring obscenity as defined in Ill. Rev. Stat. 1983 1991, ch. 38, par. 11-20 [720 ILCS 5/11-20] will be permitted.

(Source: Amended at 18 Ill. Reg. ___, effective ___)

Section 270.95 Liquefied Petroleum Gas

No liquefied petroleum gas installations will be allowed on the

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State Fairgrounds until the lessee has received approval from the State Fire Marshal (see 41 Ill. Adm. Code 200). ~~This approval, in writing, shall be placed on file in the Space Rental office before the business will be allowed to open.~~ No liquified petroleum gas will be allowed in any State building at any time.

(Source: Amended at ___ Ill. Reg. ___, effective _____)

Section 270.130 Distributing Literature or Display Advertising

A lessee may distribute literature or display advertising signs within the rented space only. Under no circumstances will any person, firm or organization be permitted to place advertising on State buildings, exterior or interior, fences, trees, or poles within the Fairgrounds. Notwithstanding anything in this Section, the Department has the right to place corporate sponsor's acknowledgement on buildings, fences, or poles within the fairgrounds.

(Source: Amended at ___ Ill. Reg. ___, effective _____)

Section 270.135 Payment of Space Rental Contract

All fees for space rental shall be paid in full at the time upon the signing of the contract is signed. A signed contract and full payment must be ~~is~~ returned to the Space Rental Office prior to July 1. Failure to return said contract and fees shall make the contract void. ~~Personal and company checks will be accepted as payment of lessee's space rental contract up to sixty (60) days before the fair, after which time payments on contracts must be in cash, money order, certified or cashier's check. Payment of fees shall be in the form of cash, a money order, or a certified cashier, or company check. No personal checks will be accepted.~~

(Source: Amended at ___ Ill. Reg. ___, effective _____)

Section 270.140 Operational Hours

All exhibits and concessions shall be ready in Springfield by 8:00 a.m. and in DuQuoin by 10:00 a.m. on the opening day of the annual State Fair. Buildings shall be open at 9:00 10:00 a.m. and shall close at 10:00 9:00 p.m. daily. If the situation warrants an earlier closing (e.g., electrical failure, natural disaster, adverse weather conditions), it may be allowed but permission to do so must be granted by the Superintendent of the Division or a duly

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authorized representative. ~~Concessions and exhibits shall operate as set forth in their concession and/or exhibit contract.~~

(Source: Amended at ___ Ill. Reg. ___, effective _____)

Section 270.150 Sales During the State Fair

For those persons subject to a percentage rental contract, the State of Illinois shall be entitled to a percent of all gross sales during the State Fair. The percentage rate shall be subject to a negotiated written contract between the concessionaire and the Department. The percentage rate in the contract shall be based on the following factors: cost of operation of the concession, profit margin, anticipated gross revenue of the concessionaire, previous experience, selling price, and other factors which could influence the negotiated rate. ~~In no case shall the percentage rate be less than 15% of the gross sales.~~

(Source: Amended at ___ Ill. Reg. ___, effective _____)

Section 270.165 Gambling, Raffles, Prizes, Games of Chance, Intoxicating Beverages

a) No ROVING gambling, games of chance or skill, raffles, selling tickets or taking donations on a chance to win a prize will be permitted.

b) The lessee will neither use nor permit to be used any games of chance or skill, raffles, selling tickets, taking donations, gambling devices, or intoxicating beverages, unless approved in writing by the Superintendent of the Division. Such approval shall be granted if the lessee's activities are not prohibited by Article 28 of the Criminal Code of 1961 (Ill. Rev. Stat. 1983 1991, ch. 38, par. 28-1 et seq.) [720 ILCS 5/28] and if the lessee agrees to abide by subsection (c) of this Section. A raffle means when a person purchases a ticket for the purpose of winning a specific item. A drawing means when a person is entitled to win a specific item without purchasing a ticket for such purpose.

c) The lessee shall abide by the following requirements when permitted to solicit at the State Fair for prizes to be given through drawings:

- 1) The drawing(s) and solicitation must be approved in

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advance of the starting of the State Fair by the Superintendent of the Division or a duly authorized representative. Approval of the drawing time, place and date will be based on the fact that there is no conflict with nor a detrimental effect on other events or exhibits.

- 2) The prize(s) shall be on display the entire length of the State Fair.
- 3) The date and time of the drawing shall be advertised in advance so the participants and other interested persons may witness the drawing.
- 4) In the event of inquiry by the public, the Department shall require the lessee who held the drawing(s) to furnish to the Space Rental Office, the name, address, and telephone number of the winner(s).

(Source: Amended at ___ Ill. Reg. ___, effective _____)

Section 270.170 Inside Exhibits

Inside exhibits shall not exceed 8 feet in height, height on back wall. Booth side walls or wings from the center of the booth to the aisle shall not exceed 3 feet in height.

(Source: Amended at 18 Ill. Reg. ___, effective _____)

Section 270.180 Clean-Up

All dining halls, lunch booths, refreshment pavilions or other stands shall be substantial in structure and neat in appearance (e.g., wood or metal frame, paneled, painted or decorated). Only paper cups will be used. No styro-foam cups will be allowed. The Department shall be responsible for cleaning aisles for pedestrian traffic in all buildings. A lessee is responsible for keeping the area contracted for in a neat, clean and orderly manner. The Department shall contract for clean-up services and bill the lessee who fails to perform this service. The Department shall not issue a release of the lessee's property until all charges are paid.

(Source: Amended at ___ Ill. Reg. ___, effective _____)

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Section 270.190 Food and/or Drink Service Operations

Food and/or drink stands and dining halls shall comply with the Illinois Food, Drug and Cosmetic Act (Ill. Rev. Stat. 1983 1991, ch. 56 1/2, par. 501 et seq.) 410 ILCS 6201, "AN ACT to prevent the preparation, manufacture, packing, storing, or distributing of food intended for sale, or sale of food, under insanitary, unhealthful or unclean conditions or surroundings, to create a sanitary inspection, to declare that such conditions shall constitute a nuisance, and to provide for the enforcement thereof" the Sanitary Food Preparation Act (Ill. Rev. Stat. 1983 1991, ch. 56 1/2, par. 67 et seq.) 410 ILCS 6501, and the rules relating to Food Service Sanitation (77 Ill. Adm. Code 750) as enforced by the Department of Public Health.

(Source: Amended at 18 Ill. Reg. ___, effective _____)

Section 270.205 Liability

The Department shall not be responsible or liable for any damage or loss of property or for any personal injury or death of any employee, agent or servant of the lessee during the period that the lessee is located upon the premises of the State Fairgrounds while engaged in the performance of the contract. The lessee shall agree to provide Workers' Compensation Insurance as required by the Workers' Compensation Act (Ill. Rev. Stat. 1983 1991, ch. 48, par. 138.1 et seq.) [820 ILCS 305].

(Source: Amended at 18 Ill. Reg. ___, effective _____)

Section 270.210 Concessionaire's or Exhibitor's Trailers

a) Springfield State Fair:

- 1) A trailer used for storage of supplies or as an office, with a direct relationship to a specific exhibit or concession, will be assigned to a vendor supply vehicle storage area. All living units will be located in the regular campground at the appropriate fee. All storage vehicles must be properly identified with a paid supply vehicle sticker.

b) DuQuoin State Fair:

- 1) A trailer used for storage of supplies, as an

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office, or for camping, with a direct relationship to a specific exhibit or concession, will be allowed to park at the rear of said exhibit or concession only when:

- a) it is out of public view;
- b) it is located within the limits of leased space as provided for in the contract;
- c) it does not infringe upon parking or access areas; and
- d) it is properly identified with a paid supply sticker.

(Source: Amended at ___ Ill. Reg. ___, effective ___)

Section 270.221 Emergency Closing

In emergency circumstances, the State Fair Manager reserves the right to close concessions and limit operations when such actions are deemed necessary for the public health, safety, or welfare.

(Source: Added at 18 Ill. Reg. ___, effective ___)

Section 270.230 State Fair Colt Stakes Races

The State Fair Colt Stakes and all races to be run thereunder shall be run in accordance with the Department's rules (8 Ill. Adm. Code 290.110) relating to the Illinois Standardbred and Thoroughbred Breeding and Racing Programs promulgated pursuant to the Illinois Horse Racing Act of 1975 (Ill. Rev. Stat. 1983 1991, ch. 8, par. 37-31) [230 ILCS 5/31].

(Source: Amended at 18 Ill. Reg. ___, effective ___)

Section 270.235 Review Futurity Races

The Department shall contract ~~on or before July 1~~ each year with the Review Futurity Association for said association's management and supervision of all races in the Review Futurity. Copies of the contract between the Department and the Review Futurity Association shall be available upon written or oral request from the Division.

(Source: Amended at ___ Ill. Reg. ___, effective ___)

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Section 270.240 Illinois Trotting and Pacing Colt Races

The Department shall contract ~~on or before July 1~~ each year with the Illinois Trotting and Pacing Colt Association for the association's management and supervision of all races in the Illinois Trotting and Pacing Colt category. Copies of the contract between the Department and the Illinois Trotting and Pacing Colt Association shall be available upon written or oral request from the Division.

(Source: Amended at ___ Ill. Reg. ___, effective ___)

Section 270.245 Quarter Horse Races

The Department shall contract ~~on or before July 1~~ each year with the Illinois Quarter Horse Association for the Association's management and supervision of Quarter Horse racing. Copies of the contract between the Department and the Illinois Quarter Horse Association shall be available upon written or oral request from the Division.

(Source: Amended at ___ Ill. Reg. ___, effective ___)

Section 270.261 Land of Lincoln Breeders Awards for Purebred or Registered Livestock

- a) In accordance with the provisions of Section 11.1 of the "State Fair Act," the percentage of the appropriation made for the Land of Lincoln Breeders Awards for Purebred or Registered Livestock for each class or show shall be as follows:

- 1) Junior Livestock Show 16 2/3%
- 2) Beef Cattle 19%
- 3) Dairy Cattle 19%
- 4) Swine 16 2/3%
- 5) Sheep 10 2/3%
- 6) Goats 2/3%

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- 7) Light Horses and Ponies 16%
- 8) Heavy Horses 1 1/3%

b) THE DEPARTMENT SHALL ESTABLISH AND PROMOTE CONTESTS AND EXHIBITIONS OF VARIOUS CLASSES OF LIVESTOCK TO BE KNOWN AS THE "LAND OF LINCOLN BREEDERS AWARDS FOR PUREBRED OR REGISTERED LIVESTOCK." ONLY ANIMALS BRED, BORN AND MAINTAINED IN ILLINOIS AND OWNED AND EXHIBITED BY ILLINOIS RESIDENTS SHALL BE ELIGIBLE TO PARTICIPATE IN SUCH CONTESTS AND EXHIBITIONS; HOWEVER, SUCH ANIMALS SHALL BE PERMITTED OUT OF THIS STATE FOR A REASONABLE PERIOD OF TIME FOR SHOWINGS, EXHIBITIONS, BREEDING OR REPRODUCTIVE PURPOSES, OR MEDICAL TREATMENT (Section 11.1 of the State Fair Act, Ill. Rev. Stat. 1989 1991, ch. 127, par. 1711.1) [20 ILCS 210/11.1]. For the purposes of determining compliance with this Section, a reasonable period of time for permitting animals to be out of the State for showings, exhibitions, breeding, reproductive purposes or medical treatment shall be a maximum of 90 days during a fiscal year (July 1 through June 30).

(Source: Amended at 18 Ill. Reg. _____, effective _____)

SUBPART F: CERTIFICATES OF AWARD: STATE FAIR

Section 270.280 Certificates, Ribbons and Trophies

Certificates of awards, including but not limited to ribbons and trophies, shall be purchased by the Department through competitive bidding in accordance with the Illinois Purchasing Act (Ill. Rev. Stat. 1983 1991, ch. 127, par. 132.1 et seq.) [30 ILCS 505] and the rules promulgated under the authority of The Illinois Purchasing Act by the Department of Central Management Services. This rule shall not be deemed to prohibit or limit the right of any association which governs an exhibit or racing area from presenting its own trophies or awards to participants in such exhibits or racing.

(Source: Amended at 18 Ill. Reg. _____, effective _____)

Section 270.320 Camping Location

Overnight camping for campers, trailers, goosenecks or tents shall be allowed in camping area(s) as may be designated from time to time by the Department. Camping is restricted to designated area(s) only unless the camper or trailer can meet the provisions

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of section 270-210 Section 270.210(b).

Section 270.365 Intoxicating Beverages

The Department shall enter into a Space Rental contract with a concessionaire(s) for the rental of space for the sole purpose of selling beer on the State Fairgrounds. The Department reserves the right to assign the area of concession as previously stated in Sections 270.35 and 270.40. It is mutually agreed that the concessionaire(s) must comply with ~~"AN ACT relating to alcoholic beverages"~~ the Liquor Control Act of 1934 (Ill. Rev. Stat. 1983 1991, ch. 43, par. 94 et seq.) [235 ILCS 5] concerning the selling of intoxicating beverages. Granting of this privilege is in no way to be construed to restrict or prohibit any distributor of beer from engaging in sales to the concessionaire(s) granted the privilege to sell beer under this rule.

(Source: Amended at 18 Ill. Reg. _____, effective _____)

Section 270.371 Leasing Facilities During the State Fair

The Department has the right to lease various facilities during the Illinois State Fair. This lease shall be subject to a negotiated rate and shall be a special agreement. In evaluating the leasing arrangement, the Department shall consider one or more of the following criteria in determining whether to grant a privilege to a prospective lessee:

- a) The availability of the physical plant or plants on the Fairgrounds, taking into consideration the priority of preparation for the actual holding of the State Fair and the priority granted to long term tenants or users of the premises;
- b) The physical limitations and availability of space when considered in conjunction with the proposed usage and number of participants, expected visitors or patrons to the event conducted by the lessee;
- c) The security of both the physical premises and persons upon the premises of the Fairgrounds;
- d) The costs and expenses ultimately incurred by the Department in providing security for any operations of lessee;
- e) Reasonably foreseeable problems with security caused by

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either the nature of the usage or the identity of the proposed lessee or his patrons;

f.) A major consideration will be the potential profit to be derived after examination of revenues versus expenses by the Department, including any budgetary constraints on the Department;

g.) The welfare of the general community;

h.) The public service to the general community offered by the proposed usage.

i.) The financial responsibility of the proposed lessee and his/her ability to provide any special requirements that may be necessary to insure the safe, healthy and efficient usage of the premises;

j.) The legality of the proposed use of the premises;

k.) Prior experience either with a specific lessee or a specific usage to the extent that such prior experience illustrates a failure, refusal or inability of the proposed lessee to comply with the rules of this Part and/or the prior experience with a particular usage to the extent such usage results in violation of the rules of this Part or affects the general good and welfare of the Department;

l.) The safety of the public and participants and of any equipment proposed to be used by lessee;

m.) The reputation of the proposed lessee in both the local community and/or in the service or trade community in which he/she does business.

(Source: Added at Ill. Reg. _____, effective _____)

Section 270.395 Removal Rights or Denial of Acceptance

a) The Department reserves the right to deny admittance of or to cause to be removed from the State Fairgrounds, any person, exhibit, animal, concession or show that may be falsely represented or to deny acceptance of or to cause to be removed from the State Fairgrounds any sign, banner, display material or advertising matter if such exhibit/display material or advertising matter is contrary to law, or in violation of the Department's

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valid interest in providing for the health, safety and/or protection of the public.

b) Pandering shall be prohibited as provided for in Article 11 of the Criminal Code of 1961 (Ill. Rev. Stat. 1993 1991, ch. 38, par. 11-16 et seq.) [720 ILCS 5/11-16]. Any person or persons objecting to the decision of the Department pursuant to this rule shall avail themselves of the Department's administrative procedure for contested cases if they desire to question the decision. In the event that the Director or his duly authorized representative determines that immediate action as set forth above must be undertaken to protect the public from substantial injury and irreparable harm, a hearing (see Section 270.20(b)) must be scheduled for the benefit of the person against whom the action is taken and a hearing conducted within 15 hours from the time the removal notice or denial is given.

(Source: Amended at 18 Ill. Reg. _____, effective _____)

Section 270.480 Gambling, Raffles, Prizes, Games of Chance, Intoxicating Beverages

a) The lessee will neither use nor permit to be used any games of chance or skill, raffles, selling tickets, taking donations or gambling devices unless approved by the Superintendent of the Division. Approval shall be granted if it is not prohibited by Article 28 of the Criminal Code of 1961 (Ill. Rev. Stat. 1993 1991, ch. 38, pars. 28-1 et seq.) [720 ILCS 5/28] and if the lessee agrees to comply with Subpart J of the rules of this Part and with Subsection (b) of this Section.

b) The lessee shall abide by the following requirements when permitted to solicit on the State Fairgrounds for prizes to be given through drawings:

1) The drawing(s) and solicitation must be approved by the Superintendent of the Division or a duly authorized representative and so stated on the contract. Approval of the drawing time, place and date will be based on the fact that there is no conflict with or detrimental effect on other events or exhibits.

2) The prize(s) shall be on display for the entire

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length of contracted event.

3) The date and time of the drawing shall be advertised in advance so the participants and other interested persons may witness the drawing.

4) When requested by the public, the Department shall request the lessee who held the drawing(s) to furnish to the Space Rental Office, the name, address and telephone number of the winner(s).

c) The space rental contract shall state if any intoxicating beverages are to be present at the event. No intoxicating beverages shall be dispensed or consumed, unless in accordance with "An Act in relation to alcoholic liquors".

(Source: Amended at 18 Ill. Reg. _____, effective _____)

Section 270.510 Limit on Duration of Contract

No space rental commitment will be considered nor any annual concession, exhibitor contract entered into in excess of one year from the date of the proposed usage. Notwithstanding anything in this section, the Department reserves the right to enter into multiple year special agreements pursuant to a negotiated rate for concessions or exhibits.

(Source: Amended at _____ Ill. Reg. _____, effective _____)

Section 270.540 Health Laws

All food and/or drink stands and concessions must be operated in compliance with the Illinois Food, Drug and Cosmetic Act (Ill. Rev. Stat. 1983-1991, ch. 56 1/2, par. 501 et seq.) [410 ILCS 6201, "AN ACT to prevent the preparation, manufacture, packing, storing, or distributing of food intended for sale, or sale of food, under insanitary, unhealthful or unclean conditions or circumstances, to create a sanitary inspection, to declare that such conditions shall constitute a nuisance, and to provide for the enforcement thereof" the Sanitary Food Preparation Act (Ill. Rev. Stat. 1983-1991, ch. 56 1/2, par. 67 et seq.) 410 ILCS 6501, and the rules relating to Food Service Sanitation (77 Ill. Adm. Code 750) enforced by the Illinois Department of Public Health. If a concession is closed by the Department of Public Health, the lessee shall have no refund due from the Department of Agriculture.

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(Source: Amended at 18 Ill. Reg. _____, effective _____)

Section 270.625 Rent Payable

a) Contract payments are payable to the Space Rental Office according to the following schedule:

1) Any barn or stall rental of 7 days or more is payable in advance by the first working day of each month.

2) Barn or stall rental of 6 days or less (for transient horses) is payable in advance at the time of arrival on the Fairgrounds.

3) Horse Show/Sale or Cattle Show/Sale barn or stall rental is payable no later than three days following the event.

b) Any additions to the number of rented stalls or tack rooms during the period of any agreement will be charged as set forth in the Space Rental Fee Schedule. Payment for succeeding months will be made on the first working day of each month and acceptance of payment by the Department will constitute the renewal of the contract with the lessee. The Department is not obligated to accept such payment, and may thus refuse to renew the lease at the end of any month in accordance with provisions of Section 270.495. Lack of a lease is grounds for removal from assigned space and the State Fairgrounds in conformance with the Illinois Forcible Entry and Detainer Act, Ill. Rev. Stat. 1983-1991, ch. 57-110, par. 1-2 et seq. [735 ILCS 5/91, or other applicable laws of the State of Illinois.

(Source: Amended at 18 Ill. Reg. _____, effective _____)

Section 270.685 Track Usage

The use of the Coliseum and track(s) is not a guaranteed condition of any contract. The Department will make every effort to keep all facilities in usable condition. Only horses in the barns in the northeast corner of the grounds north of the poultry building and west and south of the trailer park will be permitted to use the mile track or the cinder half mile track. Riding or leading horses on streets except in route to a practice area is prohibited. Only

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authorized vehicles shall be permitted on the track. Vehicles operated by non-Department personnel must obtain permission from either the Superintendent of the Division of Administrative Services or the Division of Fairs and Horse Racing, or their duly authorized representative, to operate a vehicle on the track. Unauthorized vehicles on the track will be cause for cancellation of a contract or lease.

(Source: Amended at ___ Ill. Reg. ___, effective ___)

ILLINOIS REGISTER

DEPARTMENT OF CONSERVATION

NOTICE OF PROPOSED AMENDMENTS

- 1) HEADING OF THE PART: Squirrel Hunting
- 2) CODE CITATION: 17 Ill. Adm. Code 690
- 3) SECTION NUMBERS:

690.10	<u>PROPOSED ACTION:</u>
690.20	Amendments
690.30	Amendments
- 4) STATUTORY AUTHORITY: Implementing and authorized by Sections 1.2, 1.3, 1.4, 2.1, 2.2, 2.28 and 3.5 of the Wildlife Code (Ill. Rev. Stat. 1991, ch. 61, pars. 1.2, 1.3, 1.4, 2.1, 2.2, 2.28, and 3.5) [520 ILCS 5/1.2, 1.3, 1.4, 2.1, 2.2, 2.28 and 3.5].
- 5) A COMPLETE DESCRIPTION OF THE SUBJECTS AND ISSUES INVOLVED:
These amendments replace the northern and southern hunting zones with a statewide season, update sites open to hunting and update site specific information.
- 6) WILL THIS PROPOSED RULE REPLACE AN EMERGENCY RULE CURRENTLY IN EFFECT? No
- 7) DOES THIS RULEMAKING CONTAIN AN AUTOMATIC REPEAL DATE? No
- 8) DO THESE PROPOSED AMENDMENTS CONTAIN INCORPORATIONS BY REFERENCE? No
- 9) ARE THERE ANY OTHER PROPOSED AMENDMENTS PENDING ON THIS PART?
No
- 10) STATEMENT OF STATEWIDE POLICY OBJECTIVES: This rule has no impact on local governments.
- 11) TIME, PLACE AND MANNER IN WHICH INTERESTED PERSONS MAY COMMENT ON THIS PROPOSED RULEMAKING: Comments on the proposed rule may be submitted in writing for a period of 30 days following publication of this notice to:

Jack Price
Department of Conservation
524 S. Second Street, Room 485
Springfield, IL 62701-1787
- 12) INITIAL REGULATORY FLEXIBILITY ANALYSIS: This rule does not affect small businesses

THE FULL TEXT OF THE PROPOSED AMENDMENTS BEGINS ON THE NEXT PAGE:

DEPARTMENT OF CONSERVATION

NOTICE OF PROPOSED AMENDMENTS

TITLE 17: CONSERVATION
CHAPTER I: DEPARTMENT OF CONSERVATION
SUBCHAPTER b: FISH AND WILDLIFE

PART 690

SQUIRREL HUNTING

Section

690.10 Hunting Zones/Seasons

690.20 Statewide Regulations

690.30 Regulations at Various Department-Owned or -Managed Sites

AUTHORITY: Implementing and authorized by Sections 1.2, 1.3, 1.4, 2.1, 2.2, 2.28 and 3.5 of the Wildlife Code (Ill. Rev. Stat. 1991, ch. 61, pars. 1.2, 1.3, 1.4, 2.1, 2.2, 2.28, and 3.5) [520 ILCS 5/1.2, 1.3, 1.4, 2.1, 2.2, 2.28 and 3.5].

SOURCE: Adopted at 5 Ill. Reg. 8017, effective July 24, 1981; codified at 5 Ill. Reg. 10642; emergency amendment at 5 Ill. Reg. 11382, effective October 14, 1991, for a maximum of 150 days; amended at 6 Ill. Reg. 9642, effective July 21, 1982, amended at 7 Ill. Reg. 8809, effective July 15, 1983; emergency amendment at 7 Ill. Reg. 9690, effective August 1, 1983, for a maximum of 150 days; amended at 8 Ill. Reg. 16789, effective August 30, 1984, amended at 9 Ill. Reg. 11614, effective July 16, 1985; amended at 10 Ill. Reg. 15601, effective September 16, 1986; amended at 11 Ill. Reg. 9549, effective May 5, 1987; amended at 12 Ill. Reg. 12246, effective July 15, 1988; amended at 13 Ill. Reg. 10606, effective June 15, 1989; amended at 14 Ill. Reg. 10816, effective June 20, 1990; amended at 15 Ill. Reg. 10012, effective June 24, 1991; amended at 16 Ill. Reg. 11087, effective June 30, 1992; amended at 17 Ill. Reg. 10842, effective July 1, 1993; amended at 18 Ill. Reg. _____, effective _____.

Section 690.10 Hunting Zones/Seasons

a) ~~The Southern Zone is as follows: That portion of Illinois south of U.S. Route 36 (New Rt. 36) from the Indiana state line west to Springfield; west of State Route 29 from Springfield to Pekin; south of State Route 9 from Pekin west to Dallas City and due west to the Mississippi River.~~

b) ~~The Northern Zone covers the remainder of the state.~~

Season dates: August 1 through December 31 (except closed during firearm deer seasons, as set by 17 Ill. Adm. Code 650, in those counties open to firearm deer hunting.

DEPARTMENT OF CONSERVATION

NOTICE OF PROPOSED AMENDMENTS

(Source: Amended at 18 Ill. Reg. _____, effective _____)

Section 690.20 Statewide Regulations

a) Fox squirrels and gray squirrels (including their black color phase) are the only tree squirrels that may be hunted or taken.

b) ~~Southern zone season dates: August 1 through December 31 (except closed during firearm deer seasons, as set by 17 Ill. Adm. Code 650).~~

c) ~~Northern zone season dates: September 1 through December 31 (except closed during firearm deer seasons, as set by 17 Ill. Adm. Code 650, in those counties open to firearm deer hunting).~~

d) ~~Hunting hours: Sunrise until sunset.~~

e) ~~Daily limit: 5 fox and gray (including their black color phase), squirrels, singly or in combination.~~

f) ~~Possession limit: 10 fox and gray (including their black color phase) squirrels, singly or in combination, except on opening day of the season when only 5 squirrels may be in possession.~~

(Source: Amended at 18 Ill. Reg. _____, effective _____)

Section 690.30 Regulations at Various Department-Owned or -Managed Sites

a) All the regulations in 17 Ill. Adm. Code 510, General Hunting and Trapping on Department-Owned or Managed Sites, apply in this Part, unless this Part is more restrictive.

b) Only those sites listed in this Section marked with an asterisk (*) allow hunting with .22 caliber rimfire firearms or muzzle-loading black powder rifles.

c) Statewide season regulations shall apply at the following sites (exceptions are listed in parentheses):

Anderson Lake Conservation Area

DEPARTMENT OF CONSERVATION

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Argyle Lake State Park

Big Bend Conservation Area

Big River State Forest

* Cache River State Natural Area (~~Little Black Slough Hunting Area~~)

* Cache River State Natural Area (~~Lower Cache River Hunting Area~~)

* Campbell Pond Wildlife Management Area

Carlyle Lake Lands and Waters - Corps of Engineers managed lands

* Carlyle Lake Wildlife Management Area (in the waterfowl Management Area from opening day to 3 days before the waterfowl season)

* ~~Chauncey Marsh (permit required, may be obtained at Red Hills State Park headquarters, no hunting in dedicated Nature Preserve, must return permit by February 15)~~

* Crawford County Conservation Area

* Dog Island Wildlife Management Area

Eldon Hazlet State Park (~~North~~north of Allen Branch and west of Peppenhorst Branch; north of Allen Branch only has a check station)

* Fort De Chartres Historic Site (hunting with muzzleloading firearms or bow and arrow)

Fort Massac State Park (east of Massac Creek only)

Green River State Wildlife Area (Lee County Conservation Area) (September 6 - October 31)

I-24 Wildlife Management Area

* Kaskaskia River Fish and Wildlife Area (Doza Creek waterfowl Management Area closed 3 days prior to and during duck season)

DEPARTMENT OF CONSERVATION

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Kickapoo State Park (~~free permit required, obtain from site office, hunters must return permit and report harvest by February 15 or hunting privileges for following year will be forfeited~~)

Kidd Lake State Natural Area

* Kinkaid Lake Fish and Wildlife Area

* Lake Shelbyville-Kaskaskia and West Okaw Wildlife Management Area (no handguns)

Mackinaw State Fish and Wildlife Area (September 1 - October 14)

* Marseilles Fish and Wildlife Area (Monday through Thursday from September 9 through October 31)

Marshall State Fish and Wildlife Area

* Mermet Lake Conservation Area (from opening day through the day before the opening of the duck season)

~~Middle Fork Fish and Wildlife Area (free permit required, obtain from site office, hunters must return permit and report harvest by February 15 or hunting privileges for following year will be forfeited)~~

* Mississippi River Pools 16, 17, 18, 21, 22, 24, 25, 26

* Oakford Conservation Area

* Panther Creek Conservation Area

* Pike County Conservation Area (no hunting after November 30 in Area A; no hunting after December 15 in Area C)

Ramsey Lake State Park

Randolph County Conservation Area

Red Hills State Park

* Rend Lake Project Lands and Waters

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- * Saline County Conservation Area (North of the township road)
- Sam Dale Lake Conservation Area
- Sam Parr Fish and Wildlife Area

- * Sand Ridge State Forest (from opening day through the day before the opening of the rabbit hunting season; hunters must sign out at the hunter check station)

- * Sangamon County Conservation Area

- * Sanganois Conservation Area

- * ~~Shawnee National Forest, LaRue-Seatters-~~

- * Shawnee National Forest, Oakwood Bottoms (non-toxic shot only)

- * ~~Site M (Season dates and additional regulations will be as announced by the Department; hunting is permitted in designated areas only; parking is permitted at designated parking areas only; hunters must sign in and sign out at the hunter check station)~~

Stephen A. Forbes State Park

- * Sunspot Mine (Fulton and Schuyler Counties)

Tapley Woods State Natural Area (~~closed during fall firearm-turkey season~~)

- * Ten Mile Creek State Fish and Wildlife Area (permit required; areas designated as Refuge are closed to all access during Canada Goose Season only; windshield cards must be displayed on dashboard of vehicle; permit must be returned by February 15 to District Wildlife Manager, P.O. Box 313, Olney, IL 62450)

- * Trail of Tears State Forest

- * Turkey Bluffs State Fish and Wildlife Area

Washington County Conservation Area

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Weinberg-King State Park

- * Wildcat Hollow State Forest

- * Witkowsky State Wildlife Area (season opens November 1)

- d) Season dates shall be the day following Labor Day to the end of the statewide season at the following sites:

Ferne Clyffe State Park

Giant City State Park

Hamilton County Conservation Area

Pere Marquette State Park

Pyramid State Park

Saline County Conservation Area (south of Township Road)

Siloam Springs State Park

Walnut Point Fish and Wildlife Area (season closes October 31)

- e) The following season dates shall apply on the following sites (exceptions to statewide hours are listed in parentheses):

Castle Rock State Park; September 1 - October 15

Chain O'Lakes State Park (opens Wednesday after permit pheasant season for five consecutive days, except closed on Christmas Day; 8:00 a.m. to 4:00 p.m.; hunters must check in and check out; daily quota filled on first-come, first-serve basis; DOC issued back patch must be worn while hunting; only shot size of No. 5 lead or No. 3 steel or smaller may be used)

- * Horseshoe Lake Conservation Area, Alexander County Public Goose Hunting Area, August 1 - October 15; other portions of Public Hunting Area open during statewide season

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Iroquois County Conservation Area; September 1 - 30

Johnson Sauk Trail State Park; September 15¹⁶ - 30

Jubilee College State Park; September 1-30 (Sunrise - 4:00 p.m.)

Kankakee River State Park; September 1-30

Moraine View State Park; September 1 - day before opening of site's permit pheasant season (Sunrise - 4:00 p.m.)

Silver Springs State Park; September 1 - 30 in Areas B and C; harvest must be reported before leaving the site; daily quota filled on first-come, first-serve basis

Spring Lake Conservation Area; September 10 - 30 (Sunrise - 4:00 p.m.)

* Union County Conservation Area - Public goose Hunting Area; August 1 - October 15; other portions of Public Hunting area open during statewide season

Woodford County Conservation Area; September 1 -30

f) Statewide regulations as provided in this Part apply at the following sites with exceptions noted in parentheses. In addition, hunters must obtain a free permit from site office. Permits must be in possession while hunting. The permit must be returned and harvest reported by February 15 or hunter will forfeit hunting privileges for that site for the following year.

* Chauncey Marsh (permit may be obtained at Red Hills State Park headquarters; no hunting in dedicated Nature Preserve)

Clinton Lake State Park

Eagle Creek State Park (Season opens September 15)

* Fox Ridge State Park (no handguns)

* Hidden Springs State Forest (.22 rimfire rifles and muzzle-loading rifles permitted after October 1 only; no handguns)

DEPARTMENT OF CONSERVATION

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Kickapoo State Park

* Lake Shelbyville Eagle Creek Wildlife Management Area (no handguns)

Middle Fork Fish and Wildlife Area

Mt. Vernon Propagation Center (August 1-September 30; sunrise to 12:00 Noon; site permit required; report by October 15 of lose hunting privileges the following year)

(Source: Amended at 18 Ill. Reg. _____, effective _____)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED REPEALER

1) The Heading of the Part:

The Illinois Formulary for the Drug Product Selection Program

2) Code Citation:

77 Ill. Adm. Code 790

3) Section Numbers:

790.20
790.40
790.60
790.80
790.100
790.120
790.140
790.160
790.180
790.200
790.220
790.240
790.260
790.280
790.300
790.320

Proposed Action:

Repealer
Repealer
Repealer
Repealer
Repealer
Repealer
Repealer
Repealer
Repealer
Repealer
Repealer
Repealer
Repealer
Repealer
Repealer
Repealer

4) Statutory Authority:

Implementing and authorized by Section 3.14 of the Illinois Food, Drug and Cosmetic Act (Ill. Rev. Stat. 1991, ch. 56 1/2, par. 503.14) [410 ILCS 620/3.14] and Section 25 of the Pharmacy Practice Act (Ill. Rev. Stat. 1991, ch. 111, par. 4145) [225 ILCS 85/25].

5) A Complete Description of the Subject and Issues Involved:

These repealed rules will be replaced by new emergency rules which became effective on the same date as the repeal of the existing rules and appear in this issue of the Illinois Register.

6) Will this Rulemaking Replace an Emergency Rule Currently in Effect?Yes ☒ No ☐7) Does this Rulemaking Contain an Automatic Repeat Date?

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NOTICE OF PROPOSED REPEALER

Yes ☐ No ☒8) Does this Rulemaking Contain any Incorporations by Reference?Yes ☐ No ☒9) Are there any other Proposed Amendments Pending on this Part?Yes ☐ No ☒If yes:

Section Numbers Proposed Action Ill. Reg. Citation

10) Statement of Statewide Policy Objectives:

This rulemaking will not require expenditures by units of local government.

11) Time, Place, and Manner in which Interested Persons May Comment on this Rulemaking:

Interested persons may present their comments concerning these rules by writing to Gail M. DeVito, Division of Governmental Affairs, Illinois Department of Public Health, 535 West Jefferson, Fifth Floor, Springfield, Illinois 62761, within 45 days after this issue of the Illinois Register

These rules may have an impact on small businesses. In accordance with Sections 3.01 and 4.03 of the Illinois Administrative Procedure Act, any small business may present their comments in writing to Gail M. DeVito at the above address.

Any small business (as defined in Section 3.10 of the Illinois Administrative Procedure Act commenting on these rules shall indicated their status as such in their comments.

12) Initial Regulatory Flexibility Analysis:A) Date Rulemaking was Submitted to the Business Assistance Office of the Department of Commerce and Community Affairs:B) Type of Small Businesses Affected:

None

C) Reporting, Bookkeeping or Other Procedures Required for Compliance:

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NOTICE OF PROPOSED REPEALER

None.

D) Types of Professional Skills Necessary for Compliance:

None.

The full text of the Proposed Repealer is identical to the text of the Emergency Repealer which appears in this issue of the Illinois Register on page _____.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED RULES

1) The Heading of the Part:

The Illinois Formulary for the Drug Product Selection Program

2) Code Citation:

77 Ill. Adm. Code 790

3) Section Numbers:

790.10
790.20
790.40
790.50
790.60
790.65
790.80

Proposed Action:

New Section
New Section
New Section
New Section
New Section
New Section
New Section

4) Statutory Authority:

Implementing and authorized by Section 3.14 of the Illinois Food, Drug and Cosmetic Act (Ill. Rev. Stat. 1991, ch. 56 1/2, par. 503.14) [410 ILCS 620/3.14] and Section 25 of the Pharmacy Practice Act (Ill. Rev. Stat. 1991, ch. 111, par. 4145) [225 ILCS 85/25].

5) A Complete Description of the Subject and Issues Involved:

This rulemaking clarifies and codifies the Department's full authority, as specified in the Illinois Food, Drug and Cosmetic Act, to determine the equivalency of drug products irrespective of the products' status with the Federal Food and Drug Administration (FDA). The rule implements the process whereby the Department may review pharmaceuticals not subject to an approved FDA new drug application. Such products may include "grandfathered" drugs (those marketed before the implementation of the 1938 federal Food, Drug and Cosmetic Act) and DESI drugs (products subject to the Drug Efficacy Study Implementation, a federally, statutorily mandated review of products originally marketed between 1938 and 1962, in order to determine the products' safety and efficacy). Pharmaceuticals marketed under federal provisions allowing "identical, related or similar" ("IRS") dosage forms are also available for equivalency determinations.

6) Will this Rulemaking Replace an Emergency Rule Currently in Effect?

Yes ☒ No ☐

7) Does this Rulemaking Contain an Automatic Repeal Date?

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Yes ___ No ✓8) Does this Rulemaking Contain any Incorporations by Reference? YesYes ___ No ✓9) Are there any other Proposed Amendments Pending on this Part? YesYes ___ No ✓

If yes:

Section Numbers Proposed Action Ill. Reg. Citation

10) Statement of Statewide Policy Objectives:

This rulemaking will not require expenditures by units of local government.

11) Time, Place, and Manner in which Interested Persons May Comment on this Rulemaking:

Interested persons may present their comments concerning these rules by writing to Gail M. DeVito, Division of Governmental Affairs, Illinois Department of Public Health, 535 West Jefferson, Fifth Floor, Springfield, Illinois 62761, within 45 days after this issue of the Illinois Register

These rules may have an impact on small businesses. In accordance with Sections 3.01 and 4.03 of the Illinois Administrative Procedure Act, any small business may present their comments in writing to Gail M. DeVito at the above address.

Any small business (as defined in Section 3.10 of the Illinois Administrative Procedure Act commenting on these rules shall indicated their status as such in their comments.

12) Initial Regulatory Flexibility Analysis:

A) Date Rulemaking was Submitted to the Business Assistance Office of the Department of Commerce and Community Affairs:

B) Type of Small Businesses Affected:

None.

C) Reporting, Bookkeeping or Other Procedures Required for Compliance.

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None.

D) Types of Professional Skills Necessary for Compliance:

None.

The full text of the Proposed Rules is identical to the text of the Emergency Rules which appears in this issue of the Illinois Register on page ____.

DEPARTMENT OF TRANSPORTATION

NOTICE OF PROPOSED RULES

1) Heading of Part: Prequalification of Contractors and Issuance of Plans and Proposals

2) Code Citation: 44 Ill. Adm. Code 650

3) Section Numbers:

650.10 650.150 650.290
650.20 650.160 650.300
650.30 650.170 650.310
650.40 650.180 650.320
650.50 650.190 650.330
650.60 650.200 650.340
650.70 650.210 650.350
650.80 650.220 650.360
650.90 650.230 650.370
650.100 650.240 650.380
650.110 650.250 650.390
650.120 650.260 650.400
650.130 650.270
650.140 650.280

Proposed Action:

New Section
New Section
New Section
New Section
New Section
New Section
New Section
New Section
New Section
New Section
New Section
New Section
New Section

4) Statutory Authority: Implementing Section 6 of the Illinois Purchasing Act (Ill.Rev.Stat. 1991, ch. 127, par. 132.6) [30 ILCS 505/6] and Section 4-103 of the Illinois Highway Code (Ill.Rev.Stat. 1991, ch. 121, par. 4-103) [605 ILCS 5/4-103] and authorized by Section 4-201.1 of the Illinois Highway Code (Ill.Rev.Stat. 1991, ch. 121, par. 4-201.1) [605 ILCS 5/4-201.1] and Section 5.2 of the Illinois Purchasing Act (Ill.Rev.Stat. 1991, ch. 127, par. 132.5.2) [30 ILCS 505/5.2].

5) A complete description of the subjects and issues involved: The Department of Transportation awards competitively bid contracts to the lowest responsible and responsive bidder. This Part establishes a uniform method for the Department of Transportation to make a preliminary determination of responsibility of potential contractors bidding on Department advertised projects to satisfactorily complete contracts awarded by the Department. This Part also establishes the mechanism by which proposals for bidding are issued. Additionally, this Part details the financial and work capacities of potential contractors to aid in the contract award process.

6) Will this proposed rulemaking replace an emergency rule currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this proposed rule contain incorporations by reference? No

DEPARTMENT OF TRANSPORTATION

NOTICE OF PROPOSED RULES

9) Are there any other amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: Local governments are not required to establish, expand or modify their activities in response to this rulemaking.

11) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking:

Any interested party may submit written comments or arguments concerning this proposed rule. Written submissions shall be filed with:

Mr. Robert Hinton, Bureau Chief
Bureau of Construction
Illinois Department of Transportation
Division of Highways
2300 South Dirksen Parkway, Room 322
Springfield, Illinois 62764
(217) 782-6667

Comments received within thirty days of the date of publication of this Illinois Register will be considered. Comments received after that time will be considered, time permitting.

JCAR requests, comments and concerns regarding this rulemaking should be addressed to:

Christine Caronna-Beard, Rules Manager
Illinois Department of Transportation
2300 South Dirksen Parkway, Room 300
Springfield, Illinois 62764
(217) 782-3215

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses affected: This Part does not regulate the activity of small businesses. However, those small businesses who desire prequalification must comply with this Part.

B) Reporting, bookkeeping or other procedures required for compliance: This Part does not regulate small business and thus does not establish compliance requirements; however, this Part does require audited financial statements in order to obtain a financial rating of greater than \$350,000.00.

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- C) Types of professional skills necessary for compliance: To obtain a financial rating of greater than \$350,000.00, the applicant must file an audited financial statement prepared by a Certified Public Accountant.

The full text of the Proposed Rule(s) begins on the next page:

DEPARTMENT OF TRANSPORTATION

NOTICE OF PROPOSED RULES

TITLE 44: GOVERNMENT CONTRACTS, PROCUREMENT
AND PROPERTY MANAGEMENT
SUBTITLE B: SUPPLEMENTAL PROCUREMENT RULES
CHAPTER IX: DEPARTMENT OF TRANSPORTATION

PART 650

PREQUALIFICATION OF CONTRACTORS AND
ISSUANCE OF PLANS AND PROPOSALS

SUBPART A: PREQUALIFICATION

Section	
650.10	Purpose
650.20	Definitions
650.30	Introduction to Prequalification
650.40	Application Requirements
650.50	Time for Submission
650.60	Public Disclosure of Contractor Information
650.70	Waiver of Prequalification
650.80	Issuance and Effect of Ratings
650.90	Effective Date of Ratings
650.100	Expiration Date of Ratings
650.110	Denial or Revocation of Ratings
650.120	Extension of Ratings
650.130	Revisions to Prequalification Ratings
650.140	Transfer of Prequalification Ratings
650.150	Reconsideration and Appeal
650.160	Financial Rating - General
650.170	Financial Statement
650.180	Balance Sheet Schedules
650.190	Other Factors Considered in Determining Financial Ratings
650.200	Methods of Improving a Financial Rating
650.210	Computation of Financial Rating
650.220	Work Rating - General
650.230	Determination of Work Ratings
650.240	Performance Factor
650.250	Experience Factor (EF)
650.260	Equipment Factor (Eq F)
650.270	Capacity to Perform (CP)
650.280	Calculation of Work Ratings

SUBPART B: ISSUANCE OF PLANS AND PROPOSALS

Section	
650.290	Advertising for Bids
650.300	Request for Proposal Forms and Plans; Authorization to Bid
650.310	Affidavit of Availability

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650.320 Analyzing Requests for Authorization to Bid
 650.330 Issuance of Authorizations to Bid
 650.340 Joint Ventures
 650.350 Denial of Authorization to Bid

650. APPENDIX A AVAILABLE WORK CATEGORIES
 650. APPENDIX B REQUEST FOR EXTENSION OF PREQUALIFICATION RATINGS
 650. APPENDIX C FINANCIAL PLEDGE LETTERS
 650. APPENDIX D FINANCIAL VERIFICATION LETTER
 650. APPENDIX E CORPORATE RESOLUTION

AUTHORITY: Implementing Section 6 of the Illinois Purchasing Act (Ill.Rev.Stat. 1991, ch. 127, par. 132.6) [30 ILCS 505/6] and Section 4-103 of the Illinois Highway Code (Ill.Rev.Stat. 1991, ch. 121, par. 4-103) [605 ILCS 5/4-103] and authorized by Section 4-201.1 of the Illinois Highway Code (Ill.Rev.Stat. 1991, ch. 121, par. 4-201.1) [605 ILCS 5/4-201.1] and Section 5.2 of the Illinois Purchasing Act (Ill.Rev.Stat. 1991, ch. 127, par. 132.5.2) [30 ILCS 505/5.2].

SOURCE: Adopted at ___ Ill. Reg. ___, effective _____.

SUBPART A: PREQUALIFICATION

Section 650.10 Purpose

a) The purpose of this Part is to establish policies and procedures to allow the Illinois Department of Transportation (the Department) to fulfill its obligations to award all construction and maintenance contracts to the lowest responsive and responsible bidder by prequalifying contractors to determine their responsibility.

b) A prequalification rating grants neither a license to do business nor a right to bid on or to be awarded a Department contract. It is a preliminary determination of the responsibility of a bidder, who is otherwise in compliance with the procurement rules of the Department, to do the work of a construction or maintenance contract advertised by the Department. Contractors prequalified by this Part may also be used by units of local government on contracts approved for letting and award by the Department.

Section 650.20 Definitions

"Act" - The Illinois Purchasing Act (Ill.Rev.Stat. 1991, ch. 127, par. 132.6) [30 ILCS 505/6].

DEPARTMENT OF TRANSPORTATION

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"Affidavit of Availability" - A sworn affidavit indicating all work under contract, pending awards, all subcontracts and value of subcontracts.

"Affiliate" - A member of a group of two or more companies related to one another through common ownership.

"Applicant" - Any prospective contractor who has applied for prequalification in compliance with the procedures delineated in this Part.

"Application for Prequalification" - A package of forms titled "Contractor's Statement of Experience and Financial Condition" (Form BC-8) required to be submitted by an applicant in support of its request for a prequalification rating.

"Available Bidding Capacity" - The applicable available work ratings and the available financial rating.

"Available Financial Rating" - Financial rating as indicated on the Certificate of Eligibility less the total value of all uncompleted work to be done with the applicant's own forces and work subcontracted to others.

"Available Work Rating" - The work rating in a particular category as indicated on the Certificate of Eligibility less all similar uncompleted work to be done with the applicant's own forces (for a listing of available work categories, see Section 650. Appendix A).

"Certificate of Appraiser" - The certification by an appraiser that the appraisal is performed with no direct or indirect interest, financial or otherwise, in the business of the applicant.

"Certificate of Eligibility" - A certificate issued to the applicant by the Department indicating the applicant's financial rating, work ratings and the effective period of prequalification.

"Combined Financial Statement" - The accounting data of affiliated companies combined to form a single economic entity.

"Consolidated Financial Statement" - The accounting data of parent and subsidiary companies combined to form a single economic entity.

"Contract" - The written agreement between the Department and the contractor setting forth the obligations of the parties thereunder, including, but not limited to, the performance of the

DEPARTMENT OF TRANSPORTATION

NOTICE OF PROPOSED RULES

work, the furnishing of labor and materials, and the basis of payment. The contract consists of the invitation for bids, the proposal, the letter of award, the contract form and contract bond, any specifications and supplemental specifications, any special provisions, any general and detailed plans, and all agreements that are required to complete the construction of the work, including contract time - all of which constitute one instrument.

"Contractor" - The individual, partnership, or corporation contracting with the Department for performance of prescribed work. An applicant which has been issued a Certificate of Eligibility.

"Department" - The Illinois Department of Transportation.

"Department of Human Rights Identification Number" - A number assigned to an applicant who has prequalified with the Department of Human Rights.

"Director" - The Director of the Division of Highways or his designee.

"District Engineer" - The engineer in charge of one of the nine districts of the Department in which the work of a contract is located.

"Engineering of Construction" - The individual responsible for directing the development of the Department's highway construction policies which assure uniform practices, interpretation and applications in Illinois.

"Financial Rating" - The measured ability of an applicant to sustain adequate cash flow for the duration of an awarded contract based on the submitted application for prequalification.

"Financial Statement" - A complete report of the applicant's financial status set forth on a balance sheet displaying the applicant's assets, liabilities, and net worth.

"Joint Venture" - Two or three contractors combining their available financial and work ratings for the purpose of bidding a construction project.

"Letter of Subordination" - A signed statement from a stockholder, officer, director, employee, parent, subsidiary or

DEPARTMENT OF TRANSPORTATION

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affiliate agreeing not to withdraw a specific amount of money loaned to the applicant during the period of prequalification.

"Net Worth" - Total assets minus total liabilities.

"Official Newspaper" - The one designated as such by the Department of Central Management Services.

"Parent" - A corporation which owns more than half of the stock of another corporation.

"Prequalification" - The rating process established by the Department which requires all prospective bidders to obtain a Certificate of Eligibility prior to being considered for issuance of bidding proposal forms and plans for any contract awarded by the Department, as well as, contracts awarded by local agencies requiring approval of award by the Department.

"Prequalification Section" - The section within the Bureau of Construction of the Department responsible for determining financial ratings, work ratings, and the issuance of bidding proposals.

"Request for Proposal Forms and Plans and Request for Authorization to Bid" - A form provided by the Department to assist a contractor in making a formal request for plans and proposal forms, and subsequent authorization to bid on one or all of the proposals requested.

"Service Bulletin" - The public document which is the official publication and invitation issued by the Department for bids on construction projects.

"Specialty Items" - Items that are designated in the contract documents that are considered to require specialized construction techniques that are not ordinarily available in contracting organizations qualified to bid.

"Standard Specifications" - A Department publication entitled Standard Specifications for Road and Bridge Construction which sets forth the contract provisions for road and bridge construction.

"Subsidiary" - A corporation having more than half of its stock owned by another corporation.

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"Unlimited Rating" - A financial rating in excess of \$75 million or a work rating in excess of \$25 million.

"Working Capital" - Current assets less applied discounts and current liabilities.

"Work Rating" - The dollar value of work of a particular category of construction that an applicant can perform with his/her organization and equipment in one construction season.

Section 650.30 Introduction to Prequalification

a) As required by this Part, each bidder shall be prequalified prior to being considered for issuance of an Authorization to Bid on contracts advertised by the Department.

b) Except as otherwise provided in Section 650.70 of this Part, in order to become prequalified, an applicant shall submit an application for prequalification using the prescribed forms furnished by the Department.

c) Upon receipt of a completed application, the Prequalification Section evaluates the information and calculates a prequalification rating for the applicant.

d) The prequalification rating is a combination of two subratings: the financial rating and the work rating. The policies and procedures used by the Prequalification Section to determine these two subratings are delineated in this Subpart.

e) After the Prequalification Section determines the applicant's prequalification ratings, the applicant is issued a Certificate of Eligibility. This certificate permits the applicant, now a prequalified contractor, to make application for Authorization to Bid on contracts within the contractor's available bidding capacity in accordance with Subpart B of this Part.

f) Pursuant to the Act, an applicant must also be prequalified or submit evidence of application with the Illinois Department of Human Rights (IDHR) prior to obtaining any bidding proposal forms and plans for contracts which are subject to the competitive bidding requirements of the Act. Information and forms concerning the rules of IDHR may be obtained from:

Illinois Department of Human Rights
Public Contracts Division

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100 West Randolph - Suite 10-100
Chicago, Illinois 60601
(312) 793-2431

g) Pursuant to Section 13.05 of the Business Corporation Act of 1983 (Ill.Rev.Stat. 1991, ch. 32, par. 13.05) [805 ILCS 5/13.05], out-of-state contractors are required to secure a certificate from the Illinois Secretary of State authorizing them to do business in Illinois. The certificate must be obtained prior to the execution of a contract. Application forms can be obtained from:

Illinois Secretary of State
Corporation Division
Centennial Building
4th Floor
Springfield, IL 62756
(217)782-1834

Section 650.40 Application Requirements

a) The Department shall furnish an application for prequalification to all prospective contractors who request such material. Requests shall be made by letter or telephone to:

Illinois Department of Transportation
Bureau of Construction, Prequalification Section
2300 South Dirksen Parkway, Room 322
Springfield, Illinois 62764
(217) 782-6667

b) An application for prequalification shall be submitted on the form furnished by the Department and in accordance with this Part.

c) An application for prequalification shall consist of the following information:

- 1) The applicant's name, address, telephone number and telefax number;
- 2) The applicant's Federal Employer's Identification Number (F.E.I.N.) or social security number if the applicant does not have a F.E.I.N.;
- 3) The applicant's Illinois Department of Human Rights Identification Number;

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- 4) The applicant's completed Statement of Experience and Financial Condition.
- 5) All other information required by this Part or requested by the Prequalification Section.

Section 650.50 Time for Submission

- a) The Department's Prequalification Section must receive the completed application for prequalification no later than 4:30 p.m. prevailing time no later than twenty-one days prior to the scheduled date of the letting for which the applicant desires to bid. If the day of receipt falls on a holiday, the following work day will determine the cut-off. The Department gives public notice of the letting dates and cut-off dates in the Service Bulletin. The Prequalification Section will make its determination at least three days prior to the relevant letting date. Additional information to amend current prequalification ratings is also subject to the above submission requirements.
- b) If additional projects are advertised for a letting through the issuance of a supplemental bulletin, the day of receipt for application forms or additional information is seven days from the date of issuance of the supplemental bulletin to submit bids on those projects advertised in the supplemental bulletin.

Section 650.60 Public Disclosure of Contractor Information

The Department will, to the extent permitted by law, maintain and treat all of the contractor's information as confidential and for use only by the Department or other governmental agencies entitled by law or by agreement to use such information.

Section 650.70 Waiver of Prequalification

Prequalification may be waived for selected contracts advertised in the Service Bulletin. In such contracts, the manner of determining bidder responsibility will be stated in the advertised contract and Service Bulletin. Contracts where such waiver may be made include, but are not limited to, contracts which require specialized skills not covered by available work categories, contracts for furnished manufactured products or contracts where waiver is necessary to achieve sufficient competition. However, contractors must still obtain an Illinois Department of Human Rights identification number and comply with the procedures of Subpart B of this Part.

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Section 650.80 Issuance and Effect of Ratings

- a) Once the Prequalification Section has completed its analysis of all information relevant to the determination of ratings and has established the ratings of the applicant, a Certificate of Eligibility will be issued to the applicant. A copy of the Certificate of Eligibility will be provided to requesting units of local government.
- b) The Certificate of Eligibility permits the prequalified contractor to make application for bidding proposal forms and plans for contracts in accordance with the procedures of Subpart B of this Part. The Certificate of Eligibility may be used by units of local government as evidence of contractor eligibility to bid on contracts advertised and awarded by the units of local government with approvals by the Department as required by law.
- c) The Certificate of Eligibility and the ratings therein confer neither a license nor a right to bid on or to be awarded a contract. Prequalification is an initial, preliminary determination of responsibility which must be finally determined at the time of award and execution of a contract advertised by the Department or at the time of approval in the case of contracts subject to Department approval by law.

Section 650.90 Effective Date of Ratings

The effective date of a Certificate of Eligibility shall be the date on which the ratings are determined and approved unless the application or additional information is received during the prequalification cut-off period (see Section 650.50 of this Part) in advance of a letting. In that instance, the effective date shall be the day following the letting or the date on which the ratings are determined and approved, whichever is later.

Section 650.100 Expiration Date of Ratings

All prequalification ratings issued by the Department will expire sixteen months from the date of the financial statement (balance sheet). The expiration date of current ratings will be shown on the Certificate of Eligibility issued to the contractor. Four months prior to the expiration date of the Certificate of Eligibility, the Department will mail application forms to the prequalified contractor for its use if it intends to submit a renewal application in accordance with Section 650.50 of this Part. The provisions of this Part shall apply to all current prequalification ratings issued before the adoption of this Part.

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Section 650.110 Denial or Revocation of Ratings

a) Prequalification ratings will be denied, or previously issued ratings will be revoked, in the event the Department finds the applicant or contractor to be nonresponsible. Reasons or events for a finding of nonresponsibility include but are not limited to the following. The Department shall be notified by the applicant or prequalified contractor of any information known to them which is relevant to any of the following reasons:

- 1) that the applicant failed to provide complete information regarding each item and schedule set forth in the application for prequalification or otherwise requested by the Department;
- 2) that the applicant provided false information regarding the application;
- 3) that the applicant is suspended pursuant to Section 6(d) of the Illinois Purchasing Act (Ill.Rev.Stat. 1991, ch. 127, par. 132.6(d)) [30 ILCS 505/6(d)] by the Department or another State agency;
- 4) that the applicant is suspended or debarred by the United States through a federal agency;
- 5) that the applicant is suspended by the Department of Labor pursuant to Section 11a of the Prevailing Wage Act (Ill.Rev.Stat. 1991, ch. 48, par. 39s-11a) [820 ILCS 130/11a];
- 6) that the applicant is suspended or debarred by reason of bid rigging or bid rotating convictions pursuant to the provisions of Article 33E of the Criminal Code of 1961 [720 ILCS 5/33E];
- 7) that the applicant is debarred by the operation of the antibribery provisions of Section 10.1 of the Illinois Purchasing Act (Ill.Rev.Stat. 1991, ch. 127, par. 132.10-1) [30 ILCS 505/10.1];
- 8) that the applicant is suspended by operation of the antifelony conviction provisions of Section 10.3 of the Illinois Purchasing Act (Ill.Rev.Stat. 1991, ch. 127, par. 132.10-3) [30 ILCS 505/10.3];

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- 9) that the applicant is suspended or debarred pursuant to the operation of the Drug Free Workplace Act (Ill.Rev.Stat. 1991, ch. 127, par. 132.316) [30 ILCS 580/6];
- 10) that the applicant is an individual and debarred by operation of the Educational Loan Default Act (Ill.Rev.Stat. 1991, ch. 127, par. 3551) [5 ILCS 385/1];
- 11) that the applicant is prequalified in an unaudited status and is awarded \$600,000 in transportation contracts during a twelve month period.
- 12) that the applicant has failed to comply with the requirements of this Part;
- 13) that the applicant has filed for protection from creditors pursuant to the bankruptcy laws of the United States;
- 14) that the applicant's performance evaluation is at or below the levels provided in Section 650.240(e) and (f) of this Part; or
- 15) that the applicant has failed to execute a contract after award or has defaulted on any contract or contracts awarded or approved for award by the Department after the adoption of this Part.

- b) If an application is denied or prequalification is revoked by the Department, the applicant shall be sent a notice of denial or revocation in lieu of a Certificate of Eligibility setting forth the reason or reasons for denial or revocation.

Section 650.120 Extension of Ratings

- a) A temporary extension of prequalification ratings due for expiration may be granted by the Department for good cause which may include, but not be limited to, the following examples.
 - 1) The contractor has changed the fiscal year end of the company.
 - 2) The contractor has changed the certified public accountant who will perform the audit after the audit has started.
 - 3) The contractor has been granted an extension for filing taxes by the Internal Revenue Service.

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- 4) The contractor's records have been destroyed by fire, wind, water, or such other similar event beyond the contractor's control.
- 5) The contractor's certified public accountant requests an extension of time because of a heavy workload of tax returns.
- 6) The contractor's certified public accountant is unable to complete the audit due to his/her illness.
- 7) The certified public accountant is unable to complete the audit due to illness of the sole owner, stockholder, officer or director of the company being audited.
- 8) The contractor has a minor organizational change involving ownership, officers or directors without financial impact. An extension will not be granted due to organizational changes involving an acquisition by the contractor.
- 9) The contractor changes from individual to corporate status.
- 10) The contractor changes from partnership to corporate status.
- b) A request for an extension must be received by the Department in writing no later than 4:30 p.m. prevailing time on the day of expiration of the prequalification ratings. If this day falls on a holiday or weekend, then the following work day will determine the cut-off. The exception for accepting receipt of an extension request is the twenty-one day prequalification period in advance of a letting established in Section 650.50 of this Part. Extensions will not be granted if the request for extension is received during the twenty-one day prequalification cut-off period in advance of a letting and the prequalification ratings expire prior to that letting.
- c) Extensions will be given in thirty day increments with the maximum extension being ninety days.
- d) Requests for a thirty, sixty or ninety day extension shall include:
 - 1) A letter from the certified public accountant detailing the reason for the request (see Section 650. Appendix B of this Part).
 - 2) Submittal of an adjusted trial balance sheet as of the audit date. This shall be provided by the certified public accountant for sixty and ninety day extension requests only.

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- e) Extensions of sixty or ninety days will not be granted if the adjusted trial balance sheet shows more than a 20 percent reduction in the contractor's financial rating.
- f) Extensions of thirty, sixty or ninety days will not be granted if such extensions have been granted for two consecutive prior ratings before the current request.
- g) Extensions will not be granted to contractors who are prequalified in an unaudited status or contractors who are changing from an audited status to an unaudited status.

Section 650.130 Revisions to Prequalification Ratings

- a) Revision to the financial rating may be necessary during the period it is in effect if there has been a change in status of the contractor due to reasons or events including but not limited to the following. The Department may require a contractor to file a new financial statement at any time it considers such action to be warranted. The statement shall be filed within thirty days of such request. The prequalification of a contractor who fails to file the requested information will be revoked pursuant to Section 650.110 of this Part. The Department shall be notified by the contractor when it has knowledge of any of the following reasons or events.
 - 1) The contractor has an organizational change involving ownership.
 - 2) The contractor acquires or is acquired by another company.
 - 3) The contractor incurs equipment or plant expenditures through purchase, lease or rental which totals 5 percent or more of the calculated value of the financial rating for a period of one year after the date of the financial statement. Notification of an equipment or a plant purchase should include the following:
 - A) Description (i.e., make, model, year, serial number and size or capacity);
 - B) Purchase date;
 - C) Purchase price;
 - D) Book or appraised value; and

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- E) Financial transaction (i.e., cash purchase or how financed)
- 4) Reduction of any subordinated long term notes or accounts payable.
- 5) Reduction of any long term notes before their due date.
- 6) The contractor incurs unanticipated stock repurchases within the period of one year after the date of the financial statement.
- 7) Contingent liabilities which are paid within one year of the financial statement.
- 8) Payment of the cash surrender value of life insurance.
- 9) The contractor incurs a judgment against it due to a lawsuit.
- 10) The contractor defaults on a loan agreement which is encumbered or pledged by current or fixed assets of the firm.
- 11) The contractor defaults on a contract not awarded or approved for award by the Department.
- 12) The contractor has experienced an event which has a present or future financial impact or reduction in working capital during the prequalification period. Subsequent events which represent a present or possible future reduction in working capital during the prequalification period will be reviewed and the Department will issue new ratings if the reduction in working capital exceeds 30 percent. The Department may request verification from the CPA when applicable.
- b) Revision to a work rating may be necessary during the period it is in effect for events or reasons including but not limited to the following. The Department may require the contractor to provide additional information or verification of information affecting a work rating at any time it considers such actions to be warranted. Failure to provide requested information will result in revocation pursuant to Section 650.110 of this Part. The Department shall be notified if any of the following occur:
 - 1) Departure of key staff.
 - 2) Sale of equipment required to maintain the work rating.

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- 3) Cancellation of an equipment lease or rental required to maintain the work rating.
 - c) No revision of a prequalification rating requested by a contractor will be effective for a particular letting unless a revised application for prequalification or other supplemental information pertaining to changes is received within the time specified by Section 650.50 of this Part.
 - d) Revision of a prequalification rating initiated by the Department shall be effective when issued.
 - e) A revision involving the name, phone number or address of a contractor will not affect prequalification ratings. However, the Department should be notified of these changes as soon as they occur.
- Section 650.140 Transfer of Prequalification Ratings
- a) When corporations share common stock ownership, and all corporations are prequalified by the Department, the rating of each company may be interchanged. The portion of the rating transferred may not exceed the level of common ownership expressed as a percentage. For example, 40 percent of the stock of Company A and 30 percent of the stock of Company B are owned by the same stockholder. In this case, up to 40 percent of Company A's rating may be transferred to Company B, and up to 30 percent of Company B's rating may be transferred to Company A.
 - b) Prequalified corporations may elect to be treated as affiliated for the purpose of rating transfer. In order for a company to be treated as affiliated with another, at least 51 percent of each class of stock shall be owned by the same stockholder or the same entity. The transferee need not be the wholly owned subsidiary of the transferor; all that need be established for purposes of a prequalification transfer is 51 percent controlling stock ownership between the companies. For example, 51 percent of the stock of Company A and 100 percent of the stock of Company B are owned by the same stockholder. In this case, all or part of Company A's rating may be transferred to Company B and all or part of Company B's rating may be transferred to Company A if the companies elect to be treated as affiliates for prequalification purposes. Otherwise, the companies may still follow the limited rating transfer of the common stock ownership rule which would limit Company A's transfer to 51 percent.

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c) Some conditions are common to both rating transfer methods.

- 1) The financial statement (balance sheet) of both the transferor and the transferee shall have a common date.
- 2) The request to transfer prequalification ratings shall be in writing from the transferor and shall include the following:

- A) The amount of financial rating or work rating(s) to be transferred.
- B) The extent of common ownership between the companies.
- C) A statement that the transfer is for the remaining duration of the prequalification period.

D) The signature of the transferor.

- 3) Corporations shall provide a corporate resolution which authorizes the transfer of prequalification ratings (see Section 650. Appendix E of this Part).

- 4) A parent company shall submit the Certified Assumption and Guarantor Agreement contained in the application for prequalification when transferring a financial rating to a subsidiary.

- 5) The rating of the transferor will be reduced by the amount of increase in the transferee rating.

- 6) A contractor with an unaudited rating may not receive a financial rating transfer which causes its prequalification rating to exceed the \$350,000 limit.

- 7) A contractor with an unaudited rating may not transfer a financial rating to a contractor with an audited rating.

- 8) Only one transfer of ratings between the same transferor and transferee will be recognized during the prequalification period.

- 9) No transfer of a prequalification rating requested by a contractor will be effective for a particular letting unless evidence (in the form of a written request) is received within the time specified by Section 650.50 of this Part.

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Section 650.150 Reconsideration and Appeal

- a) If an applicant is denied ratings, a contractor has its ratings revoked, a contractor has its ratings revised, or, an applicant is issued incorrect ratings on a Certificate of Eligibility, the applicant or contractor may request reconsideration by notifying the Prequalification Section by filing a written Request for Reconsideration within thirty days of the issue date on the face of the Certificate or of the date on the notification of denial or revocation.

- b) A Request for Reconsideration shall clearly state the basis of the request and be supported by information of the type required by this Part which would indicate that the ratings should be amended or that the action of the Prequalification Section should be modified or reversed.

- c) The Engineer of Construction will review the Request for Reconsideration and the applicant or contractor shall provide any additional requested information for purposes of the review. The review will be completed within 14 days after receipt unless the Engineer extends the time for review in order to provide for a full and complete review. Upon completion of the review, the Engineer of Construction shall notify the applicant of the results and provide the applicant or contractor with an amended Certificate of Eligibility or written confirmation of the previous determination or action including an explanation of the reasons for the confirmation.

- d) If the applicant or contractor remains unsatisfied with the results of the Engineer of Construction review, the applicant or contractor may file a written appeal to the Director within fourteen days of the date of the Engineer of Construction final action.

- e) The appeal shall state with specificity the basis of the appeal and the reasons why the decision of the Engineer of Construction is incorrect. No new issues may be raised. The appeal shall further state whether the applicant or contractor requests an opportunity to make a verbal presentation to the Director.

- f) The Director will review all information submitted with the appeal and will consider the verbal presentation of the applicant or contractor. The appeals will be completed within 14 days after receipt unless the Director extends the time in order to provide for a full and complete review. The Director will notify the

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applicant or contractor of his decision in writing and shall include an explanation of the reasons for the decision. The decision of the Director shall be final.

Section 650.160 Financial Rating - General

a) The financial rating serves two functions.

- 1) To measure the applicant's ability to sustain cash flow for the duration of an awarded contract.
- 2) To indicate the maximum amount of uncompleted work that the applicant may have under contract at any one time.

b) When computing an applicant's financial rating, the Department utilizes the financial statement submitted by the applicant as part of the application for prequalification.

c) The Department shall consider any applicant with a net worth of \$20 million or a financial rating in excess of \$75 million to have an unlimited financial rating.

Section 650.170 Financial Statement

An applicant may obtain a financial rating in either an audited or unaudited status. Audited financial information provides the Prequalification Section with reliable information whereas, unaudited financial information is subject to certain restrictions as provided for in subsection (c) of this Section.

a) Audited Status

The Department will require all applicants seeking an audited status to adhere to the following:

- 1) An applicant shall submit the Department's "Certificate of Accountant" with the completed financial statement. An Independent Auditor's Opinion Letter is acceptable in lieu of the Certificate of Accountant, if the applicant desires to submit only the balance sheet and auditor's notes.
- 2) All data shall be secured from an audit conducted no more than twelve months prior to the time the financial statement is received by the Department.
- 3) Financial statements which are only compiled or reviewed by a CPA are not accepted for prequalification in an audited status.

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4) The audit of the applicant's records shall be conducted in accordance with the accounting principles approved by the American Institute of Certified Public Accountants (AICPA) as published in "Statement of Auditing Standards No. 46: Omnibus Statement on Auditing Standards," AICPA, January, 1989.

5) The financial statement shall be prepared by a Certified Public Accountant (CPA), who has been licensed by the Illinois Department of Professional Regulation, or an out-of-State CPA who has been issued a license by that State. A financial statement will be considered unaudited if prepared by a non-licensed CPA.

6) No certified financial statement will be accepted which has been prepared by an accountant who has a direct or indirect interest, financial or otherwise, in the business of the applicant submitting the statement.

7) The applicant shall submit a report prepared by the CPA who conducted the audit if the Department's Certificate of Accountant is not submitted. The report shall contain the following information:

- A) name, address, and telephone number of the accounting firm involved with the audit;
- B) the license number, State of license, expiration date of license and signature of the CPA conducting the audit;
- C) the date of audit;
- D) the degree of responsibility assumed by the CPA; and
- E) the accountant's opinion (see subsection (b) of this Section).

b) Opinion of Certified Accountant

An accountant's opinion is a report that either contains an expression of opinion regarding the financial statements, taken as a whole, or an assertion to the effect that an overall opinion cannot be expressed. When the latter occurs, the CPA should state the reasons. There are several types of opinions a CPA can issue:

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1) Unqualified opinion - an opinion which contains no exceptions or subsections and conveys the CPA's belief that the financial statement presents a fair and accurate statement of the applicant's financial position. An unqualified opinion is the most desirable because it allows the applicant to obtain audited status. Additionally, the unqualified opinion enables the Department to accept the applicant's financial statement with the confidence that the audit was conducted in accordance with generally accepted auditing standards; that the CPA acquired all the information necessary to render an informed opinion; and, that the same accounting principles were used as those used in the preceding year.

2) Qualified opinion - an opinion which contains an exception or subsection. An exception indicates that the CPA is not in agreement with a certain accounting principle, while a subsection indicates that accounting principles were circumvented due to an uncontrollable circumstance, such as pending litigation. When a qualified opinion is in order, the CPA shall express the reason(s) for the qualification, the approximate amount involved, and the overall effect on the financial statement. Depending on the impact of these three factors, the Department may or may not accept the opinion for prequalification purposes. If the Department chooses not to accept the opinion, the applicant's financial statement will preclude prequalification in an audited status.

3) Adverse opinion - an opinion expressing the CPA's belief that the applicant's financial statement does not present a fair and accurate statement of the applicant's financial position and any resulting exceptions are so material that the CPA cannot justify issuing a qualified opinion. Pursuant to the rendering of an adverse opinion, the CPA shall disclose all substantive reasons for issuing such an opinion in his report. The Department shall view the applicant's financial statement as unaudited, thereby, precluding prequalification in an audited status.

4) Disclaimer of opinion - a report used when a CPA believes an opinion cannot be expressed. Pursuant to the rendering of a disclaimer, the CPA shall present the reasons for refusing to express an opinion, such as client imposed restrictions. The Department shall view the applicant's financial statement as precluding prequalification in an audited status.

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c) Unaudited Status

The Department will require all applicants seeking an unaudited status to adhere to the following:

1) The unaudited status is subject to the following limitations.

A) the applicant's financial rating shall be limited to no more than \$350,000;

B) the applicant shall not have been awarded more than \$600,000 in transportation contracts, including Local Agency Motor Fuel Tax contracts, during any twelve month period. If this condition occurs subsequent to the issuance of a Certificate of Eligibility, the prequalification ratings will automatically expire.

2) The financial statement shall be prepared by either the applicant or an accountant. It is not necessary that the statement be prepared and certified by a licensed accountant. The financial statement:

A) must be prepared from data secured from the applicant's records;

B) must not be more than twelve months old at the time of receipt by the Department;

C) must be completed and in balance; and,

D) the financial information release must be completed and submitted by the applicant's financial institution to verify account balances.

d) Interest in Other Contracting Firms

1) If an individual, a member of a partnership, or an officer or director of a corporation is interested financially in more than one company, the accountant shall submit a letter explaining such interest, the extent of the investment, and the individual relationship with such companies. The Department may require these individuals to furnish financial statements from these companies as of the same date as the financial statement submitted by the applicant requesting prequalification.

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- 2) Each applicant shall disclose in the application for prequalification, the name of each individual having a beneficial interest of 7 1/2 percent or more in the firm seeking prequalification. If the company is a corporation, the name of all the officers and directors and their respective position shall be disclosed.

Section 650.180 Balance Sheet Schedules

In order to provide for the determination of ratings in as objective a manner as possible, the Department has established specific evaluations and classifications for a number of financial rating items. The value attached to the affected financial rating items shall be calculated by decreasing its face value by the discount established in this Part for that item. Where a valuation or classification materially affects an applicant's financial rating, and insufficient information has been submitted, the Department may ask for clarification or substantiation of a classification made by the accountant in preparing the statement. The various financial rating items and their corresponding discounts are delineated as follows:

a) Current Assets

1) Schedule A - Cash

Cash includes currency, personal checks, bank drafts, money orders, cashiers checks and money on deposit with banks. The Department classifies cash as a current asset and attaches no discount, provided:

- A) Deposits made for a sole proprietorship are held in the name of either the proprietor solely, or jointly with the proprietor's spouse.
- B) Deposits made for a partnership are held either in the name of any of the general partners, or in the name of the partnership.
- C) Deposits made for a corporation are held in the name of the corporation only.
- D) Deposits are free of debt or obligation. Certificates of deposits and other cash assets which are pledged will be discounted by the amount of debt or obligation.

2) Schedule B - Notes Receivable

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Notes receivable will be evaluated and classified as follows:

- | | | |
|----|---|----------------|
| A) | Secured notes receivable due within one year | Discount
0% |
| B) | Unsecured notes receivable | 100% |
| C) | Any note receivable, or portion thereof, which will not be due and payable or is not expected to be collected within one year from the statement date | 100% |
| D) | Notes receivable from stockholders, officers, directors, employees, parent, subsidiaries and affiliates | 100% |

3) Schedule C - Certified and Cashier's Checks on Deposit

Deposits which may be included are those which are expected to be refunded within the current period or upon request of the depositor. An example is a deposit for a proposal guarantee. Purchase deposits on real estate and equipment will be included in determining the value of those fixed assets. All other deposits will be discounted 100 percent.

4) Schedule D - Accounts Receivable - Contracts

Accounts receivable from federal and State agencies for all contracts, and from local agencies for transportation contracts, are considered as current assets regardless of the contract completion date. If the applicant has completed work not covered by current pay estimates and an item for such work is shown, the accountant shall obtain evidence in writing from the parties for whom the work was performed to justify such an item. Accounts receivable shall be evaluated as follows:

- | | | |
|----|---|----------------|
| A) | From federal and State agency contracts and local agency transportation contracts. | Discount
0% |
| B) | From contractors on federal and State agency contracts and local agency transportation contracts. | 0% |

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- C) From other contracts or entities. 10%
- D) Work completed but unbilled (other entities). 10%
- E) Over one year old (other entities). 100%
- 5) Schedule E - Other Accounts Receivable
- A) Any other account receivable, such as claims for tax refunds, will be carefully considered to determine whether it constitutes an authentic receivable and is collectible within one year.
- B) Other accounts receivable shall be evaluated as follows:
- | | Discount |
|---|----------|
| i) Accounts receivable offset by accounts payable. | 0% |
| ii) Income tax refunds. | 0% |
| iii) Judgements and insurance claims receivable. | 100% |
| iv) Accounts receivable over one year old. | 100% |
| v) Accounts receivable from stockholders, officers, directors and employees. | 100% |
| vi) Accounts receivable from parent, subsidiaries and affiliates. (See the exception to this discount in subsection (vii) of this Section.) | 100% |
| vii) Accounts receivable from prequalified parent subsidiaries and affiliates whose financial statement date corresponds to the prequalifying company and whose financial statement shows a corresponding accounts payable. | 0% |
| C) Total discounts for accounts receivable will be offset by any allowance established for bad debt. | |

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- D) In determining whether the status of a receivable is current, reference will be made to the previous statements submitted by the applicant. The appearance of an item on two or more successive statements indicates that the receivable is not current and perhaps uncollectible. Therefore, the receivable will be considered noncurrent.
- 6) Schedule F - Stocks and Bonds
- A) In listing stocks, bonds, investments, etc., in Schedule F, the accountant shall show as separate items the applicant's investments in other contracting firms.
- B) Stocks, bonds and other investments are evaluated and classified as follows:
- | | Discount |
|--|----------------|
| i) Municipal, State and U.S. Bonds (cash surrender value) | 0% |
| ii) U.S. Treasury Bills (cash surrender value) | 0% |
| iii) Repurchase agreements | 0% |
| iv) Annuities and Individual Retirement Accounts | 10% |
| v) Stocks, bonds and investments, including commercial paper (book value shown on balance sheet) (market value shown on balance sheet) | 25%
33 1/3% |
| vi) Special Assessment vouchers - tax anticipation warrants | 25% |
| vii) Stocks of parent, subsidiaries, affiliates, etc., which are themselves prequalified | 100% |
| viii) Nonmarketable equities - defined as equities not readily available for public sale | 100% |

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- ix) Stock in civic organizations or social clubs (i.e. country club, co-op stock, etc.) 100%
- x) Artwork and collections 100%
- 7) Schedule G - Material in Stock
- A) Inventories are evaluated and classified as follows: Discount
- i) Verified value of material in stock for current contracts except sod and growing nursery stock 0%
- ii) Verified value of other material in stock 10%
- iii) Verified book or appraised value of sod and growing nursery stock 50%
- 8) In completing Schedule G, the accountant shall exclude the value of any material for which a material allowance has been paid.
- Schedule H - Cash Surrender Value of Life Insurance
- Cash surrender value, not face value, of life insurance is considered a current asset provided the amount of any policy loan is considered as a current liability.
- 9) Schedule I - Prepaid Items
- All prepaid items will be discounted 100%.
- 10) Schedule J - Relation of Billings and Costs
- A) This schedule is established for the convenience of those contractors that report income for Federal tax purposes on the cash method (completed contract), but who prepare financial statements on the accrual method (percentage of completion).
- B) Where the applicant classifies his billings in excess of costs as a fixed or other liability, the Department shall reclassify it as a current liability.

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- C) The discount applied to billings and costs by the Department is as follows:
- Costs in excess of billings (current assets) 10%
- b) Fixed Assets
- 1) Schedule K - Real Estate
- A) No consideration is given if title-held land and improvements are not verified by the certified public accountant for audited financial statements.
- B) The allowance for real estate is the value of title-held land and improvements less long term encumbrances from commercial lending institutions times a factor of 50 percent.
- C) The value may be based on an accredited real estate appraisal which is not more than 24 months old at the time of receipt by the Department. The appraiser's background, experience and references must be submitted. The information on the appraiser is not required if a tax assessment value is provided.
- D) An applicant shall submit the Department's Certificate of Appraiser.
- E) If an appraisal is not submitted or accepted, the allowance will be based on book value.
- F) If the net appraised or book value is less than long term encumbrances, no reclassification of excess encumbrance will be made to current liabilities if current year's payments are provided for in current liabilities.
- G) No allowances are given for oil leases, leasehold improvements, mineral leases or land lease prepayments.
- 2) Equipment
- A) In the case of audited financial statements, the

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accountant shall verify the correctness of the equipment schedule. All equipment which is still serviceable, even though fully depreciated, shall be included and listed by classification such as graders, scrapers, front-end loaders, bulldozers, cranes, etc.

B) The allowance for equipment is the value of owned construction equipment, including purchase deposits and capital leases, less long term encumbrances to commercial lending institutions times a factor of 70 percent. No value will be given for operating leases or rental equipment.

C) The value may be based on an accredited equipment appraisal (physical inspection), which is not more than 24 months old at the time of receipt by the Department. The appraiser's background, experience and references shall be submitted.

D) An applicant shall submit the Department's Certificate of Appraiser.

E) If an appraisal is not submitted or accepted, the allowance will be based on book value.

F) The accountant may restate any accelerated depreciated value to straight-line depreciation for determining book value.

G) If the net appraised or book value is less than long term encumbrances, no reclassification of excess encumbrance will be made to current liabilities if current year's payments are provided for in current liabilities.

c) Schedule L - Other Current or Fixed Assets

If an applicant lists other assets not described in this Part, they shall be described in sufficient detail to be considered. Allowances for this category include, but are not limited to, the following:

1) Nonconstruction equipment
(classify to equipment)

Discount

0%

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2) Accrued interest and dividends 10%

3) Grain and livestock 25%
(classify to inventory)

4) Interest and dividends from stockholders, officers, directors, employees, parent, subsidiaries and affiliates 100%

5) Organization expense/goodwill 100%

6) Investment credit 100%

Section 650.190 Other Factors Considered in Determining Financial Ratings

a) Notes and Accounts

1) Long term notes and accounts payable to stockholders, officers, directors, employees, parent, subsidiaries and affiliates will not be considered a liability if subordinated. A subordination is not permitted if it takes place more than one year from the date of the financial statement. Long term notes which are not subordinated will be considered as current liabilities.

2) Long term notes (which are in the company's name) payable to banks or other financial institutions when secured by the personal assets of the owners, officers or directors will be considered as additional working capital if properly subordinated.

3) Notes payable due within one year from the financial statement date are considered current liabilities. Installments on notes due beyond one year are considered deferred liabilities.

4) When notes payable are secured by all assets or current assets of a firm, the amount of the loan is deducted from the value of fixed assets (against equipment first then real estate) in determining the financial rating. No excess of encumbrance will be charged against working capital. When notes payable are unsecured, there will be no deductions from the value of fixed assets.

5) The reduction of long term notes before their due date will

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cause a reduction in the computed financial rating. In the event of long term debt reduction, the contractor shall furnish in writing the details of the transaction. This information shall be verified by a certified public accountant for those contractor's who have an audited status.

- 6) Any long term unsecured notes payable shall be accompanied by a signed statement from the lending agency and the contractor indicating that a decrease in the unsecured borrowing shall be reported to the Department immediately. In addition, the contractor shall provide a copy of the loan agreement which shall disclose the date of the loan, the termination date, the terms of payment, a statement that the loan is free of conditions and whether it is interest or noninterest bearing. Any unsecured note payable not accompanied by such a statement and loan agreement shall be considered a current liability for prequalification rating purposes.

b) Income Taxes

The Department shall utilize the maximum corporate tax rate as stipulated by the Internal Revenue Code to reclassify deferred taxes as a current liability. This situation occurs when an applicant reports its income to the Internal Revenue Service on the cash or completed contract method, but submits such to the Department on the accrual method, thus deferring 100 percent of any income taxes due on its receivables.

c) Dividends

Where dividends of the applicant, declared or proposed, have neither been paid nor included as a current liability in the submitted application for prequalification, the Department shall establish reserve distributions equal to the unpaid portion.

d) Treasury Stock

If debentures have been issued, or, if long term obligations have been assumed by an applicant for repurchase of treasury stock, the Department will not consider the long term portion of these obligations as long as the applicant has provided for repayment of any current portion.

e) Affiliated Companies

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- 1) A consolidated financial statement from the parent organization may be used to prequalify a single subsidiary company. A Certified Assumption and Guarantor Agreement must be submitted with the financial statement. The single subsidiary company is permitted to transfer its financial rating to companies included in the consolidated financial statement who desire to become prequalified.
- 2) The Department may request a consolidated or consolidating financial statement from the parent organization of a subsidiary or affiliate requesting prequalification. The Department will deny credit for assets of a subsidiary or an affiliate which are unduly burdened or otherwise heavily encumbered, and which are not available because of the financial condition of the parent organization.
- 3) A combined financial statement may be used to prequalify a single company. The affiliates of the prequalifying company shall submit a pledge letter. Corporations shall provide a corporate resolution which authorizes the pledge of assets (see Section 650.Appendix E of this Part).

f) Letters of Credit

Bank letters or letters of credit will not be considered in the computation of the financial rating.

Section 650.200 Methods of Improving a Financial Rating

- a) Personal assets of stockholders, officers, directors or employees may be pledged to improve the financial rating of the contractor seeking prequalification. See Section 650.Appendix C of this Part for information on assets acceptable to pledge and the letter required. Section 650.Appendix D of this Part illustrates the letter required from the certified public accountant for audited financial statements. The Department will not give credit for assets which are unduly burdened or heavily encumbered, and which are not available to the stockholder, officer, director or employee.
- b) Assets of a nonprequalified affiliated company may be pledged to improve the financial rating of the contractor seeking prequalification if the following conditions are met:
 - 1) The pledgor (affiliate) company and the pledgee company have at least 51 percent common controlling ownership.

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- 2) Pledging of assets by the affiliate shall consist of the submittal of a financial statement. The financial statement of the affiliate must correspond with the date of the financial statement of the pledgee. The financial statement of the affiliate shall be of the same type of financial statement (audited or unaudited) that was submitted by the company seeking prequalification.
- 3) The affiliate shall submit a pledge letter. Corporations shall provide a corporate resolution which authorizes the pledge of assets (see Section 650.200 Appendix E of this Part).
- 4) The Department will not give credit for assets which are unduly burdened or heavily encumbered, and which are not available to the affiliate.
- c) Loans which are renegotiated and involve the time frame or the encumbrance of assets of the company may be reconsidered. Only loans which total in excess of \$100,000 will be considered. A copy of the new loan agreement is required.
- d) Subsequent events which take place more than one year from the date of the financial statement will not be permitted to improve the financial rating of a company.

Section 650.210 Computation Of Financial Rating

The Department will use the financial data required by Sections 650.180, 650.190, and 650.200 of this Part to determine an applicant's financial rating by means of the formula set forth below. If the rating determined by the formula results in a negative value, the applicant will not be prequalified.

- a) Total Current Assets \$ _____ (1)
- b) Discounted Assets \$ _____ (2)
- c) Net Current Assets
(line 1 minus line 2) \$ _____ (3)
- d) Current Liabilities \$ _____ (4)
- e) Allowable Net Current Assets
(line 3 minus line 4) \$ _____ (5)
- f) Total Allowable Real Estate \$ _____ (6)

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- g) Total Allowable Equipment \$ _____ (7)
- h) Total Allowable Net Current Assets, Real Estate and Equipment
(line 5 plus line 6 plus line 7) \$ _____ (8)
- i) Multiplication Factor
(if line 8 is negative to \$200,000 use 10)
(if line 8 is between \$200,001 and \$300,000 use 11)
(if line 8 is over \$300,001 use 12) 10, 11 or 12 (9)
- j) Maximum Financial Rating
(line 8 x line 9 and round to the nearest thousand) \$ _____ (10)

Section 650.220 Work Rating - General

The work rating measures the applicant's capability to perform work in specific categories. A complete list of categories currently available is contained in Section 650.200 Appendix A of this Part.

Section 650.230 Determination of Work Ratings

- a) The work rating is expressed as the dollar value of work of a particular category that the applicant can perform with its own organization and facilities in one construction season. The Work Rating (WR) is determined using the following factors:

- 1) The Performance Factor (PF);
- 2) The Experience Factor (EF);
- 3) The Equipment Factor (EqF); and
- 4) The Capacity to Perform (CP).

- b) The General Questions form, the Experience form, the Record of Past Experience form, the Resume form, the Schedule of Contractor's Equipment form and the Affidavit of Possession form are used to calculate work ratings. Contractor performance reports (BC-1777) are also utilized (see Section 650.240 of this Part for more information concerning the Contractor's Performance Reports).

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Section 650.240 Performance Factor

a) The Performance Factor is a numerical value which is determined by the contractor's performance evaluation in a work category during the previous year. At the close of each construction season, the Department or officials of a unit of local government administering a contract approved for award by the Department will evaluate each contractor who performed work for them during the previous year either as a prime contractor or as a subcontractor. This information is submitted on the Contractor's Annual Performance Report (BC-1777). The performance evaluations are based on:

- 1) The quality of work performed for each work category defined in Section 650. Appendix A of this Part.
- 2) The overall execution of work as measured by evaluating four categories.

A) Organization and prosecution of the work;

B) Cooperation with public agency personnel responsible for contract administration and inspection;

C) Traffic control and site protection as provided by contract requirements; and

D) Compliance with EEO and labor requirements.

- b) The performance evaluation scale is a rating from 2.0 to 8.0 in accordance with the following definitions:

8.0 Excellent
7.0 Good
6.0 Satisfactory
4.0 Marginal
2.0 Poor

- c) The quality and evaluating categories under execution of work are defined and rated as follows.

1) Quality - The project's durability and appearance, the knowledge of supervisory personnel, and the compliance with contract requirements (i. e. plans, specifications, field inspection, etc.) are considered.

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2) Quality Scale

- 8.0 The contractor exceeded project requirements in all areas considered.
- 7.0 The contractor exceeded project requirements in a majority of areas considered.
- 6.0 The contractor met project requirements in all areas considered.
- 4.0 The contractor did not meet project requirements in one area considered.
- 2.0 The contractor did not meet project requirements in two or more areas considered.

- 3) Organization/Prosecution - The contractor's ability to diligently prosecute work by planning and scheduling labor, materials and the work of subcontractor's on project site are considered.

4) Organization/Prosecution Scale

- 8.0 The contractor exceeded project requirements in all areas considered and completed the project well ahead of schedule.

- 7.0 The contractor exceeded project requirements in a majority of areas considered and the project was completely slightly ahead of schedule.

- 6.0 The contractor met project requirements in all areas considered and the scheduled completion date was met.

- 4.0 The contractor did not meet project requirements in one area considered and occasionally did not work when conditions permitted. The scheduled completion date was met.

- 2.0 The contractor did not meet project requirements in two or more areas considered and the scheduled completion date was not met.

- 5) Cooperation - The contractor's willingness to negotiate contract disputes, to respond to reasonable requests by the resident engineer and to respond to various Departmental correspondence are considered.

6) Cooperation

- 8.0 The contractor exceeded project requirements in all areas considered.

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- 7.0 The contractor exceeded project requirements in a majority of areas considered.
- 6.0 The contractor met project requirements in all areas considered.
- 4.0 The contractor did not meet project requirements in one area considered.
- 2.0 The contractor did not meet project requirements in two or more areas considered.

7) Traffic Control/Site Protection - The appearance of the traffic control devices, the response to repair deficient devices and the contractor's willingness to comply with the Traffic Control Plan (TCP) are considered.

8) Traffic Control/Site Protection

- 8.0 The contractor exceeded project requirements in all areas considered.
- 7.0 The contractor exceeded project requirements in a majority of areas considered.
- 6.0 The contractor met project requirements in all areas considered.
- 4.0 The contractor did not meet project requirements in one area considered.
- 2.0 Either the contractor did not meet project requirements in two or more areas considered or the contractor committed an act or omission which seriously compromised the safety of the public.

9) EEO/Labor Compliance - The contractor's compliance with the Equal Employment Opportunity program and compliance with labor laws are considered.

10) EEO/Labor Compliance

- 8.0 The contractor exceeded project requirements.
- 7.0 The contractor met project requirements through extraordinary effort and initiative.
- 6.0 The contractor met project requirements with minimum effort and initiative.
- 4.0 The contractor met project requirements, but had to be motivated by Department personnel.
- 2.0 The contractor did not meet project requirements.

d) The Performance Factor is equal to the performance evaluation rating for quality of work divided by six. However, if a rating

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of 4.0 or less occurs in a category under execution of work as determined by the District, the District Engineer will indicate those work categories affected and will explain the problems encountered. In addition, an average value from all the categories under execution of work will be determined. If the average value for execution of work is less than the performance evaluation for quality of work, this average value will be used to determine the Performance Factor. Only those work categories indicated by the District Engineer will be affected.

e) A work rating will not be renewed or will be revoked if a performance evaluation rating of less than 4.0 in quality of work is received for two successive years.

f) A work rating will not be renewed or will be revoked if a District determines for two successive years a performance evaluation rating of 6.0 or less in the same category under execution of work. However, the Engineer of Construction will determine the work ratings to remain in effect if another District Engineer indicates satisfactory performance within that District. An explanation for allowing the work ratings to remain in effect will be provided by the Engineer of Construction.

g) The contractor shall be notified of the performance evaluation in writing within 14 days with a detailed explanation of any substandard items. If a performance evaluation results in a reduced work rating, the contractor may proceed with the review procedures in accordance with Section 650.150 of this Part.

h) If an applicant did not have a contract with the Department in the previous year, the last evaluation issued within a five year period will be used. If an applicant has not had an evaluation in the last five years or is applying for an initial rating in a category and lists no public agencies or private customers as references, a Performance Factor of "1" will be used until an actual evaluation is made.

Section 650.250 Experience Factor (EF)

a) The Experience Factor is the cumulative dollar value of work performed in a given work category by the applicant's own forces. To be given credit for this experience, the work must have been performed either for the Department or other entity the Department considers to be a source of valid and verifiable information. The experience is the total experience of the applicant as a

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continuously operating entity. Credit will not be given for work performed as an owner or employee of another firm. Applicants will receive incremental credit for successfully completed work in a work category even though the contract is not completed.

b) To accurately evaluate an applicant's experience, the following shall be provided for each project.

- 1) The project owner's name, address (City and State) and phone number.
- 2) The dollar value of work performed for each work category within the project.
- 3) The year the work was performed.

c) Applicants requesting a work rating for the first time should list experience for a minimum of three years (if available) to assist the Department in the evaluation of their capabilities. As prequalification is renewed, and subsequent records of past experience are filed, the Department will compute the cumulative dollar value of work performed for each work category.

Section 650.260 Equipment Factor (Eq F)

a) Work categories which require the applicant to have specific equipment and plant facilities are indicated in Section 650.Appendix A of this Part. Determination of work ratings in these categories requires the calculation of an Equipment Factor which measures the physical productive capacity of the applicant's equipment and facilities. Equipment Factors are based on standards which produce an average dollar value of productivity as set forth in Section 650.Appendix A of this Part. The Department may adjust the standards as necessary to reflect increases in construction costs.

b) In calculating Equipment Factors, the Department will consider:

- 1) Equipment owned outright. All equipment which is service-able will be considered even though fully depreciated.
- 2) Equipment pledged in its entirety for the exclusive use of the applicant. A stockholder, officer, director or employee of the company may pledge equipment. A parent, subsidiary or affiliate may also pledge equipment. The request to pledge shall be in writing by the pledgor and shall include the following:

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- A) The pledgor and the pledgee.
- B) The make, model, year, serial number and size or capacity of the equipment.
- C) A statement that the equipment is "pledged for the exclusive use" of the applicant.
- D) A statement that the pledge is for the "remainder of the applicant's prequalification period".
- E) The signature of the pledgor.
- F) Corporations shall provide a corporate resolution which authorizes the pledge of equipment (see 650.Appendix E of this Part).

3) Either leased or rented equipment currently in the possession of the applicant or leased or rented equipment possessed by the applicant during the previous year, whichever is greater. Possession shall be confirmed by the submittal of a signed and notarized affidavit. No credit will be given for leased equipment not in possession to establish an equipment factor. Applicants shall submit a copy of the lease agreement which must contain the following.

- A) Time period. Either a minimum twelve month period or the prequalification period is required.
- B) Make, model, year, serial number and size or capacity of the equipment.
- C) Monetary consideration.
- D) Signature of the lessee and lessor.
- E) The statement of "exclusive use" and notarization of the signatures for equipment involving a bituminous or concrete plant.

c) Credit for equipment (including plants) will not be given until the applicant provides proof that all required federal, state or local permits or licenses to operate the equipment have been obtained. The applicant shall make equipment available for inspection so the Department can verify possession and determine its serviceability. No credit will be given for equipment which

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is in disrepair or is inoperable. Equipment owned but leased to another contractor will not be considered available for a work category. Concrete plants used for retail sales will not be eligible to establish an equipment factor for the work category of Portland Cement Concrete Paving.

- d) Equipment such as front-end loaders, motor graders and cranes are versatile and can perform several types of work. If the contractor does not assign equipment to a specific category, the Department will assign the equipment on the basis of the contractor's work experience and requested ratings. The Department will not give credit for equipment which is not available for a work category. For example, an applicant may have front-end loaders which he uses in a quarry, this equipment would not be considered available for the work category of Earthwork.

Section 650.270 Capacity to Perform (CP)

- a) The Capacity to Perform represents the annual dollar value of work completed by an applicant which is related to the category of work for which a rating is requested. The work must have been performed for the Department or other entity the Department considers to be a source of valid and verifiable information. The performance of the applicant must be that as a continuous operating entity. Credit will not be given for work performed as an owner or employee of another firm.

- b) The Capacity to Perform is the average of the three highest volume years in the last ten years. If a new applicant does not have three years' experience or if there is a sustained increase in the volume of work performed, the Department will use a value which does not exceed the highest volume year as the capacity to perform.

Section 650.280 Calculation of Work Ratings

- a) Applicants assigned work ratings in the categories of Earthwork, Portland Cement Concrete Paving, Bituminous Plant Mix, Bituminous Aggregate Mixtures, Aggregate Bases & Surfaces (type A or B) and Cover & Seal Coats are required to possess specific equipment or plant facilities which are assigned Equipment Factors. Work ratings in these categories are calculated by the primary formula.

$$WR = PF (EF/2 + EqF/2) \quad (\text{Primary Formula})$$

- b) Equipment Factors based on plant production may be quite large, but new or inexperienced contractors may not be able to realize

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the full potential of their capacity. For this reason, the primary formula considers experience as well as equipment and plant capacity. In the simplest case, a new applicant with no experience and a presumed performance factor of 1.0 will receive a work rating equal to one half the calculated Equipment Factor. As the applicant gains experience, the work rating will increase. When the Experience Factor equals or exceeds the Equipment Factor, the work rating is calculated by the advanced formula below.

$$WR = PF \times EqF \quad (\text{Advanced Formula})$$

- c) All remaining work categories are calculated by the secondary formula.

$$WR = PF \times CP \times 1.2 \quad (\text{Secondary Formula})$$

- d) The secondary formula does not utilize an equipment factor because of the immeasurable productive capacity of the equipment or plant facility; however, equipment must be available to the applicant. See Section 650. Appendix A of this Part for a listing of equipment or plant facilities. The secondary formula includes a factor of 1.2 to provide a margin for growth.

- e) An applicant's capacity to perform may exceed the calculated equipment factor. This can occur by good management, efficiency and additional hours of work. When this occurs, the primary and advanced formulas will be replaced by the secondary formula.

- f) The work rating in any given category may not exceed the financial rating of the applicant.

- g) If the primary, advanced or secondary formula results in a value in excess of \$25 million, the work category will be assigned an unlimited rating provided the applicant's financial rating is unlimited.

- h) A work rating may be designated as "Illinois Work Only." This work rating indicates the dollar value of work which the applicant's own forces can perform within the State of Illinois in one construction season. This rating will be established by the Department if the applicant does work in more than one state or outside the continental United States and it would be impractical to verify all outstanding work.

- i) Prior to any consideration for establishing a work rating value, the applicant shall provide a list of all technical, supervisory

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and key personnel who would manage a project awarded by the Department. This list should include the individual's job title and number of years of construction experience. The Department may also require the submittal of resumes of the above individuals. Applicants qualifying with the Department for the first time shall be required to submit resumes. Insufficient personnel may be justification for a reduction in the rating of a work category as determined by the primary, advanced or secondary formula. Hiring of additional personnel may be justification for an increase in the rating of a work category. Applicant's without experienced personnel for a requested work category may be denied the rating.

j) Methods to Improve a Work Rating

- 1) Hiring of additional personnel.
- 2) Purchase, lease or rental of additional equipment.
- 3) Completion of additional work.

k) A contractor may request additional rating in a work category at any time during the prequalification period by submitting a revised application or supplemental information.

SUBPART B: ISSUANCE OF PLANS AND PROPOSALS

Section 650.290 Advertising for Bids

a) An advertisement for bids is published in the official newspaper of the State of Illinois.

b) The Service Bulletin is the official publication and invitation issued by the Department for bids on construction projects. It contains a brief description of the work involved in each project and the quantities of the major pay items. It also states the location and time when the bids will be opened.

c) The Service Bulletin is sent to all contractors who are prequalified with the Department. Other persons who may be interested in serving as subcontractors or material suppliers may subscribe to the Service Bulletin at the established subscription price from:

Illinois Department of Transportation
Bureau of Administration and Facility Services

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2300 South Dirksen Parkway
Springfield, Illinois 62764
(217) 782-7806

Section 650.300 Request for Proposal Forms and Plans; Authorization to Bid

A Request for Proposal Forms and Plans and Request for Authorization to Bid (Form BD-124) is attached to the Service Bulletin. The Form BD-124 shall be used by contractors to request proposals and plans and to request formal authorization to bid on contracts advertised in the Service Bulletin. Anyone may obtain proposal forms and plans regardless of prequalification status. An Authorization to Bid must be granted in accordance with this Part before a prequalified contractor may submit a bid.

Section 650.310 Affidavit of Availability

- a) An Affidavit of Availability (Form BC-57) is attached to the Service Bulletin and must be submitted with a request for Authorizations to Bid. It is a sworn statement concerning the contractor's present and pending contract commitments. The contractor shall not omit or misrepresent its work outstanding. When the contractor has uncompleted or pending work as a party of a joint venture, the contractor's responsible portion of the work shall be shown. The affidavit shall be signed by an officer or director of a corporate contractor and, otherwise, an owner shall sign. The affidavit is not required when a contractor has unlimited work ratings and an unlimited financial rating or when Authorization to Bid is not being requested. The affidavit shall include:
 - 1) The amount of all uncompleted work, by type, either as a principal or subcontractor together with the name of the agency under whose jurisdiction the work is being performed. All uncompleted work shall be based upon the engineer's or owner's most recent estimate.
 - 2) The commitment of equipment and personnel on a payroll or rental basis even though no formal contract exists.
 - 3) All work on which the contractor is the low bidder and which has not yet been awarded.
 - 4) A listing of all subcontractors and the value of work sublet.

- b) Prospective bidders shall notify the Department within two working days of any low bids pending award or contracts awarded which

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might occur between the submission of the affidavit and the opening of bids.

Section 650.320 Analyzing Requests for Authorization to Bid

- a) In analyzing a contractor's request for Authorization to Bid, it is necessary to determine the contractor's available bidding capacity.

- 1) The total value of all uncompleted work awarded to the contractor, as shown on the Affidavit of Availability, is deducted from the financial rating shown on the Certificate of Eligibility. The result is the Available Financial Rating.

- 2) The value of each type of work uncompleted and included in pending low bids the contractor will perform with its own forces as a prime or subcontractor, as shown on the Affidavit of Availability, is deducted from the corresponding category of work rating shown on the Certificate of Eligibility. The result is the Available Work Rating in each category. If a contractor has a work rating designated for "Illinois Work Only," then only Illinois work is deducted from the corresponding category of work rating.

- 3) When the proposed work requires more than one construction season (18 months or 168 working days) to complete, the work ratings shown on the Certificate of Eligibility are multiplied by the number of construction seasons required for completion. The Available Work Rating is then determined as stated in subsection (a) (2) of this Section. Similar consideration is given to work reported on the Affidavit of Availability. Each work category of a project is divided by the number of construction seasons to complete the project. The Available Work Rating is then determined as stated in subsection (a) (2) of this Section.

- 4) Contractors who have ratings in major work categories are given credit for work in applicable minor work categories. For example, a contractor with a rating in Portland Cement Concrete Paving or Structures is given credit for work in the minor work category of Miscellaneous Concrete Construction. The work category definitions in Section 650.Appendix A of this Part will indicate if a minor work category is applicable. Credit given for a minor work category is deducted from the contractor's available rating in the corresponding major work category.

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- 5) Bituminous Plant Mix is rated at \$32/ton as compared to \$26/ton for Bituminous Aggregate Mixtures. See Section 650.Appendix A of this Part. However, the plant's hourly capacity remains the same. Therefore, the dollar value of outstanding Bituminous Aggregate Mixtures shown on the Affidavit of Availability will be increased by twenty percent in determining available work rating for Bituminous Plant Mix if a contractor's plant produces both Class I and BAM.

- b) In order to be issued an Authorization to Bid, a contractor's Available Work Ratings for all applicable categories must equal or exceed 50 percent of the estimated value of the contract, less designated specialty items. For Division of Aeronautics work, the Available Work Ratings must equal or exceed 51 percent of the estimated value. A contractor's Available Financial Rating must equal or exceed 95 percent of the total estimated value of each contract. However, the low bidder will not be awarded the contract unless the Available Financial Rating equals or exceeds the actual price bid.

- c) The Department will occasionally advertise for bids a contract which consists of an item or items which are of the type commonly constructed by the Capital Development Board (such as general building construction, roofing, plumbing, heating, ventilation and air conditioning) rather than by the Department of Transportation. In such instances, the advertisement will indicate waiver of prequalification under the rules of the Department according to Section 650.70 and will specify prequalification by the Capital Development Board pursuant to 44 Ill. Adm. Code 950.

Section 650.330 Issuance of Authorizations to Bid

- a) There is no limit to the number of Authorizations to Bid issued a contractor as long as the available bidding capacity satisfies the requirements of each individual contract. If the contractor is the low bidder on two or more contracts and the sum of the bids exceeds the available bidding capacity, the Department will select the contract or contracts for award.

- b) Authorization to Bid will not be issued on requests received after 4:30 p.m. prevailing time on the cut-off date indicated in the Service Bulletin. In addition, any request to be removed from the bidder's list or to dissolve a joint venture must be received prior to the time indicated in the previous statement.

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Section 650.340 Joint Ventures

- a) Prequalified contractors may combine their available bidding capacity and request an Authorization to Bid for a single contract to bid as a joint venture after Department approval.
- b) Each request for approval of a joint venture shall be indicated by the filing of a Joint Venture Minimum Declaration of Work for each of the contracts for which joint venture approval is sought. The form is available from the Prequalification Section. It identifies the managing partner and indicates the kind and the percentage of work to be performed by each joint venture partner with its own workforce and resources other than work reserved to meet any disadvantaged business goal advertised in the contract. The form indicates the joint venture agreement shall be available to the Department for inspection. In addition, each joint venture partner firm shall submit an Affidavit of Availability. The Joint Venture Minimum Declaration of Work and all Affidavits of Availability must be received no later than 4:30 p.m. prevailing time at least seven days prior to the scheduled date of the letting for which bidding proposals are sought.

c) The proposed joint venture shall not be approved for the issuance of bidding proposals if the establishment of a joint venture would unduly restrict competition. A determination that a proposed joint venture would unduly restrict competition is limited to any of the following reasons:

- 1) That the proposed joint venture would consist of more than three prequalified contractors.
- 2) That the Joint Venture Minimum Declaration of Work indicates that any one of the proposed joint venture partners will perform less than 10 percent of the nondisadvantaged business work with its own workforce and resources.
- 3) That for letting items estimated by the Department to be bid at less than \$1,000,000.00, more than one of the proposed joint venture partners has the individual prequalification ratings and bid capacity to bid the item without the approval of the venture. This determination shall not apply to joint ventures between firms having fifty one percent or more common controlling ownership or on items where the estimated quantity of asphalt exceeds 10,000 tons or concrete exceeds 5,000 cubic yards.

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- d) Contractors whose financial ratings are based upon unaudited financial statements will not be permitted to joint venture with each other to bid contracts which are estimated to exceed \$350,000. However, such contractors may be permitted to joint venture with contractors who have a financial rating based upon an audited statement to bid contracts estimated to exceed \$350,000.
- e) If a joint venture work rating is limited by its maximum financial rating, the full value of the computed work rating will be used in analyzing the joint venture request for a bidding proposal. However, the combined maximum work rating in any category shall not exceed the combined maximum financial rating of the joint venture.
- f) If an approved joint venture is awarded a contract, the kind and percentage of work indicated on the Joint Venture Minimum Declaration of Work may be amended as many times as necessary by the contractor provided that each partner of the approved joint venture performs at least 15 percent of the work with its own workforce and resources.

Section 650.350 Denial of Authorization to Bid

The Department will not issue Authorization to Bid for any of the following reasons:

- a) The potential bidder is not prequalified under the provisions of this Part.
- b) The potential bidder will not be prequalified on the day of the scheduled letting which is the subject of the Request for Authorization to Bid.
- c) The potential bidder has uncompleted work on previously awarded contracts which, in the judgment of the Department, might hinder or prevent the prompt completion of additional work if awarded.
- d) The potential bidder has provided false information provided on a bidder's Affidavit of Availability.
- e) The potential bidder has failed to submit final documentation on any open contract or to pay, or satisfactorily settle, all bills due for labor and material on previously awarded contracts in force at the time of issuance of proposal forms.
- f) The potential bidder has failed to comply with this Part or the bidding procedures of the Department.

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- g) The potential bidder has defaulted under previous Department awarded contracts or contracts approved for award by the Department; has failed to execute an awarded contract; or has caused the readvertisement of a project through mistakes or neglect in the bidding procedures.
- h) When any agent, servant, employee, associated organization, affiliate or related entity of the prospective bidder has participated in the preparation of plans, specifications or special provisions for the proposed work.
- i) The potential bidder is subject to revocation of prequalification ratings in accordance with Section 650.110 of this Part.

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Section 650. APPENDIX A AVAILABLE WORK CATEGORIES

- 1 Earthwork
- 2 Portland Cement Concrete Paving
- 3 Bituminous Plant Mix
- 4 Bituminous Aggregate Mixtures
- 5 Miscellaneous Bituminous Paving
- 6 Cleaning and Sealing Cracks & Joints
- 7 Soil Stabilization and Modification
- 8 Aggregate Bases and Surfaces (A,B)
- 9 Structures (H,RR,M)
- 10 Structures Repair
- 11 Anchors and Tiebacks
- 12 Drainage
- 13 Drainage Cleaning
- 14 Electrical
- 15 Cover and Seal Coats (A,B)
- 16 Slurry Applications
- 17 Miscellaneous Concrete Construction
- 18 Landscaping
- 19 Seeding and Sodding
- 20 Vegetation Spraying
- 21 Tree Trimming and Selective Tree Removal
- 22 Fencing
- 23 Guardrail
- 24 Grouting
- 25 Painting
- 26 Signing
- 27 Paint Pavement Marking
- 28 Thermoplastic Pavement Marking
- 29 Epoxy Pavement Marking
- 30 Installation of Raised Pavement Markers
- 31 Pavement Texturing and Surface Removal
- 32 Cold Milling, Planing and Rotomilling
- 33 Erection
- 34 Demolition
- 35 Fabrication
- 36 Tunnel Excavation
- 37 Expressway Cleaning
- 38 Railroad (Track) Construction
- 39 Marine Construction
- 40 Hydraulic Dredging
- 41 Hot (in-place) Recycling
- 42 Cold (in-place) Recycling

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EARTHWORK

Consists of clearing, grubbing, tree removal (except selective tree removal), hedge removal, roadway excavation, channel excavation, borrow excavation, special excavation, topsoil excavation and placement, ditch excavation, common excavation, solid rock excavation, mine refuse excavation, pavement removal, hauling, embankment (earth, stone, gravel or other materials), backfilling (all types of materials), grading, compacting and trenching. This category is also applicable to projects involving Demolition (see definition), riprap installation, construction of aggregate ditch, construction of gabions, slope mattress and revetment mats (riprap or interlocking concrete blocks). In addition, this category is applicable to Seeding (see definition at Section 650.20) for Land Reclamation projects.

EQUIPMENT: Scrapers, gradalls, graders, cranes, shovels, excavators, backhoe loaders, front-end loaders, skid-steer loaders, bulldozers or fine grading equipment are required to establish a rating.

CALCULATION OF WORK RATING: Primary or advanced formula.

<u>Equipment</u>	<u>Equipment Factor (EqF)</u>
Self-propelled scrapers	\$16,000 per cubic yard of heaped capacity
Pull type scrapers	\$9,000 per cubic yard of heaped capacity
Gradalls	\$115,000 each
Graders	\$100,000 each
Cranes, shovels, excavators and backhoe loaders	\$375,000 for 3/4 cubic yard bucket size \$405,000 for 1 cubic yard bucket size \$460,000 for 1-1/4 cubic yard bucket size \$550,000 for 1-1/2 cubic yard bucket size \$635,000 for 1-3/4 cubic yard bucket size \$750,000 for 2 cubic yard bucket size \$835,000 for 2-1/2 cubic yard bucket size \$1,010,000 for 3 cubic yard bucket size \$1,210,000 for 3-1/2 cubic yard bucket size \$1,440,000 for 4 cubic yard bucket size \$1,610,000 for 4-1/2 cubic yard bucket size \$115,000 for less than or equal to 2 cubic yard bucket size
Front-end loaders	\$230,000 for 2-1-3 cubic yard bucket size \$375,000 for 3-1-4 cubic yard bucket size \$460,000 for 4-1-5 cubic yard bucket size \$605,000 for greater than 5 cubic yard bucket size
Skid-steer loaders	\$50,000 each
Bulldozers	\$200,000 each
Fine grading equipment	\$200,000 each

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PORTLAND CEMENT CONCRETE (PCC) PAVING

Consists of constructing pcc pavement, continuously reinforced pcc pavement, pcc base course and pcc base course widening, cement aggregate mixture sub-base, pozzolanic stabilized mixture sub-base and pozzolanic stabilized base course. This category is also applicable to Miscellaneous Concrete Construction (see definition at Section 650.20).

EQUIPMENT: A central mix plant, a batch plant with transit mixer trucks, formless paver and finishing machine. A concrete plant with either a formless paver or a finishing machine is the minimum equipment requirement.

CALCULATION OF WORK RATING: Primary or advanced formula. Concrete plants used for retail sales are not eligible.

<u>Equipment</u>	<u>Equipment factor (EqF)</u>
Central Mix Plant and Batch Plant*	(C.Y./Batch) X (20 Batches/Hr.) X (8 Hrs./Day) X (80 Days /Yr.) X (\$80/C.Y.) X (1.0)
Central Mix Dual Plant and Dual Batch Plant*	(C.Y./Batch) X (20 Batches/Hr.) X (8 Hrs./Day) X (80 Days/Yr.) X (\$80/C.Y.) X (1.7)

*To receive the maximum equipment factor (EqF) for a batch plant, the contractor shall possess a minimum of one transit mixer truck for every cubic yard of capacity of the plant.

BITUMINOUS PLANT MIX

The placement of bituminous concrete binder and surface course (Class I), bituminous concrete base course widening, bituminous base course, bituminous aggregate mixture stabilized sub-base, bituminous shoulder, bituminous curb, bituminous gutter, bituminous curb and gutter, bituminous sidewalk, bituminous driveway, bituminous median, bituminous patching, open graded asphalt friction course and incidental bituminous surfacing. Also includes placement and hot recycling of reclaimed aggregates and asphaltic cements, and placement and production of cold mix stabilized base. This category is also applicable to Miscellaneous Bituminous Paving (see definition at Section 650.20).

EQUIPMENT REQUIRED: A bituminous plant approved by the Bureau of Materials and Physical Research for Class I production, an approved bituminous spreading and finishing machine and compaction equipment.

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CALCULATION OF WORK RATING: Primary or advanced formula.

Plant Production Rating

Equipment Factor (EqF)

Tons Per Hour (TPH)
(Established by Bureau of Materials and Physical Research)
TPH X (8 Hrs./Day) X (80 Days/Yr.) X (\$32/Ton) X (1.00) for approved plant or tentative approval type A
TPH X (8 Hrs./Day) X (80 Days/Yr.) X (\$32/Ton) X (.50) for tentative approval type B
TPH X (8 Hrs./Day) X (80 Days/Yr.) X (\$32/Ton) X (.25) for tentative approval type C

Note: Tentative approval is an evaluation of a plant by the Bureau of Materials and Physical Research prior to final approval.

BITUMINOUS AGGREGATE MIXTURES

Consists of the placement of bituminous aggregate mixture, stabilized sub-base and bituminous shoulder. Also includes placement and hot recycling of reclaimed aggregates and asphaltic cements, and placement and production of cold mix stabilized base. This category is also applicable to Miscellaneous Bituminous Paving (see definition at Section 650.20).

EQUIPMENT REQUIRED: A bituminous plant approved by the Bureau of Materials and Physical Research, an approved bituminous spreading and finishing machine and a compaction equipment.

CALCULATION OF WORK RATING: Primary or advanced formula.

Plant Production Rating

Equipment Factor (EqF)

Tons Per Hour (TPH)
(Established by Bureau of Materials and Physical Research)
TPH X (8 Hrs./Day) X (80 Days/Yr.) X (\$26/Ton) X (1.00) for approved plant or tentative approval type A
TPH X (8 Hrs./Day) X (80 Days/Yr.) X (\$26/Ton) X (.50) for tentative approval type B
TPH X (8 Hrs./Day) X (80 Days/Yr.) X (\$26/Ton) X (.25) for tentative approval type C

Note: Tentative approval is an evaluation of a plant by the Bureau of Materials and Physical Research prior to final approval.

MISCELLANEOUS BITUMINOUS PAVING

Consists of placing bituminous base, surface, widening or shoulders with a bituminous spreading and finishing machine. This category is restricted to either 1,200 tons in any one contract (Class I or BAW) or as specified by the local agency. Bituminous curb and gutter, sidewalk, driveway, median and patching are not to be included in the tonnage determination.

EQUIPMENT REQUIRED: An approved bituminous spreading and finishing machine and compaction equipment.

CALCULATION OF WORK RATING: Secondary formula.

CLEANING AND SEALING CRACKS & JOINTS

Consists of routing and sealing cracks for asphaltic and concrete pavements.

EQUIPMENT REQUIRED: Router and melter.

CALCULATION OF WORK RATING: Secondary formula.

SOIL STABILIZATION AND MODIFICATION

Consists of constructing soil-cement base course and lime modified soils.

EQUIPMENT REQUIRED: Grader, rotary speedmixer, mechanical spreader, water tanker and compaction equipment.

CALCULATION OF WORK RATING: Secondary formula.

AGGREGATE BASES & SURFACES (TYPE A)

Consists of constructing granular sub-base, aggregate base course, aggregate surface course, aggregate shoulders and aggregate-turf pavement. Also includes construction of cement aggregate mixture sub-base, pozzolanic stabilized mixture sub-base, pozzolanic stabilized base course, lime modified soils (disc harrow method), calcium chloride applications, and sub-ballast.

AGGREGATE BASES & SURFACES (TYPE B)

Consists of hauling and spreading aggregate.

EQUIPMENT REQUIRED: Grader or mechanical spreader, and compaction equipment if applicable.

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CALCULATION OF WORK RATING: Primary or advanced formula.

<u>Equipment</u>	<u>Equipment Factor (EqF)</u>
Grader and compaction equipment (Type A)	\$375,000 each
Mechanical spreader and compaction equipment (Type A)	\$375,000 each
Grader (Type B)	\$375,000 each
Mechanical Spreader (Type B)	\$375,000 each

STRUCTURES (HIGHWAY)

Consists of excavation for structures (includes cofferdams, temporary cribs, etc.), constructing concrete structures (bridges, box culverts, etc.), membrane waterproofing, constructing steel structures (bridges, corrugated structural plate drainage structures, etc.), constructing metal railings, constructing timber structures (bridges, etc.), Erection (see definition of this and following work categories at Section 650.20), installation of reinforcement bars, piling (all types), and construction of temporary bridges. This category is also applicable to Structures Repair, Demolition, Miscellaneous Concrete Construction, Fencing and Signing.

STRUCTURES (RAILROAD)

Consists of items listed above. This category is specific to structures carrying railroad transportation.

STRUCTURES (WATERWAY)

Consists of the construction of major structures and appurtenances for water storage and distribution, flood control and recreation. This includes dams, spillways, spillway crest gates, sluiceway, sluiceway gates, canals, channel appurtenances (culverts, flumes, inverted siphons, etc.), pump stations (including mechanical equipment), aqueducts, irrigation structures (checks, dams, gates, etc.), locks and dams, dikes, groins and jetties. This category also includes excavation for structures (includes cofferdams, temporary cribs, etc.), piling (all types), de-watering and Demolition (see definition at Section 650.20).

EQUIPMENT: Bulldozers, front-end loaders, shovels, cranes, backhoe loaders, excavators, pile hammers and bridge deck finishing machines. A crane is the minimum equipment requirement. However, a crane is not required for those contractors requesting a structures rating for \$150,000 or less.

CALCULATION OF WORK RATING: Secondary formula.STRUCTURES REPAIR

Consists of bridge deck repair or bridge deck removal and replacement. This includes the use of latex modified concrete, polymer concrete, epoxy and other materials for patching, deck overlays, sealing, etc. Also includes membrane waterproofing, constructing metal railings, installation of reinforcement

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bars, superstructure repairs such as replacement of joints, replacement of bearings, beam straightening (heat or mechanical), repair and retrofit of fracture and fatigue distressed steel girders, member strengthening, etc. Substructure repairs are also included and consist of the use of epoxy, shotcrete and other materials for minor repairs of spalled or deteriorated concrete. This category is also applicable to Miscellaneous Concrete Construction, Fencing and Signing (see definitions at Section 650.20).

EQUIPMENT: Front-end loaders, cranes, backhoe loaders, excavators and bridge deck finishing machines. A crane is the minimum equipment requirement. However, a crane is not required for those contractors requesting a structures repair rating for \$150,000 or less.

CALCULATION OF WORK RATING: Secondary formula.ANCHORS AND TIEBACKS

Construction of all types of anchors and tiebacks which provide resistance to lateral and uplift forces in bridge abutments, retaining walls, bulkheads, dams, deep excavations and various support systems (underpinning, etc.).

EQUIPMENT REQUIRED: Auger or drilling equipment. Grouting equipment to include air compressor, mixing equipment, agitator-type reservoir tank and grout pump.

CALCULATION OF WORK RATING: Secondary formula.DRAINAGE

Consists of the installation and removal of precast concrete box culverts, installation and removal of pipe culverts and storm sewers, relining of pipe culverts and storm sewers, installation of pipe drains and pipe underdrains, exploration trenches for locating farm underdrains, minor boring and jacking of pipe-in-place, installation of cast iron soil pipe, installation of water mains and water service lines, adjusting sanitary sewers and water service lines, construction of catch basins, manholes, inlets, inspection holes and valve vaults, minor cleaning of catch basins, adjustment and reconstruction of catch basins, manholes, inlets, inspection holes and valve vaults, installation and adjustment of frames and grates, filling existing manholes, catch basins, inlets, wells and drainage structures, moving fire hydrants, moving domestic meter vaults and water service boxes, riprap installation, construction of aggregate ditch, installation of excelsior blanket, fiber mat and fiberglass roving, construction of gabions, slope mattress and revetment mats (riprap or interlocking concrete blocks), construction of trench and backfill for communication cables, ducts and conduits, construction of inverted siphons, construction of flumes and construction of pump stations (including mechanical equipment). This category is also applicable to de-watering projects, well drilling, slurry trench cut-off walls (soil-bentonite or cement-bentonite), and Drainage Cleaning.

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EQUIPMENT REQUIRED: Trenching machine or backhoe loader or excavator.

CALCULATION OF WORK RATING: Secondary formula.

DRAINAGE CLEANING

Consists of cleaning of pipe culverts, storm sewers and catch basins.

EQUIPMENT REQUIRED: Vacuum or jetting equipment.

CALCULATION OF WORK RATING: Secondary formula.

ELECTRICAL

Consists of the installation of electric cable, duct and conduits, construction of trench and backfill for cables, ducts and conduits, traffic surveillance and control installations, traffic signal installations, installation of light pole, installation of light tower, installation of vapor luminaire, installation of sign lighting, installation of temporary lighting systems, installation of navigational lighting systems, installation of photocell relay service, installation of airport lighting systems, installation of airport beacon towers and airport rotating beacons, and other appropriate illumination systems. This category is also applicable to electronic weigh scale installations, installation and maintenance of motorist call box systems and installation of electrical controls/mechanical equipment for pump stations.

EQUIPMENT REQUIRED: Trenching machine or backhoe loader or excavator or aerial equipment.

CALCULATION OF WORK RATING: Secondary formula.

COVER AND SEAL COATS (TYPE A)

Consists of the application of bituminous materials for priming, road oiling, cover coating and seal coating.

COVER AND SEAL COATS (TYPE B)

Consists of sealing parking lots and driveways.

EQUIPMENT REQUIRED: Distributor (Type A) or aggregate spreader (Type B).

CALCULATION OF WORK RATING: Primary or advanced formula.

Equipment	Equipment Factor (EqF)
Distributor (Type A)	\$400,000 each
Tanker Truck* (Type A)	\$ 50,000 each
Spreader (Type B)	\$400,000 each

*A maximum of two (2) tanker trucks per distributor will be allowed.

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SLURRY APPLICATIONS

Consists of slurry sealing and micro-surfacing.

EQUIPMENT REQUIRED: Slurry or micro-surfacing equipment.

CALCULATION OF WORK RATING: Secondary formula.

MISCELLANEOUS CONCRETE CONSTRUCTION

Consists of masonry work or the construction of concrete barrier, curb, gutter, combination curb and gutter, sidewalk, driveway pavement, median, paved ditch, flumes, slope wall, retaining wall, railroad crossing, pavement, base course, base course widening and all types of pavement patching. This category also includes construction of revetment mats (cast-in-place concrete slabs), construction of foundations (light pole, light tower, etc.) and various undersealing projects which allow the voids to be filled by gravity flow. Removal of concrete which consists of any of the aforementioned items or similar items is applicable to this work rating. This category is also applicable to construction of box culverts and other similar miscellaneous drainage structures. The total of pavement, base course and base course widening cannot exceed 15,000 square yards in any one contract.

EQUIPMENT: Concrete saws, generators, vibrators, forms, tampers, screeds and concrete placement equipment.

CALCULATION OF WORK RATING: Secondary formula.

LANDSCAPING

Consists of planting trees, shrubs, vines, seedlings and other materials. This category also includes applying fertilizing nutrients, mulching, watering, and Seeding and Sodding (see definition at Section 650.20).

EQUIPMENT: Auger equipment or hoe, tillers, disks, slope harrows, hydraulic seeders, cultipackers, spinning disk seeders, tractor drawn or mounted seeders, rangeland type grass drill, mulch blowers and water trucks. Auger equipment or hoe with disc and seeder is the minimum equipment requirement.

CALCULATION OF WORK RATING: Secondary formula.

SEEDING AND SODDING

Consists of seeding, sodding, applying fertilizer nutrients, mulching, watering, installation of excelsior blanket, fiber mat and fiberglass roving.

EQUIPMENT: Tillers, disks, slope harrows, hydraulic seeders, cultipackers, spinning disk seeders, tractor drawn or mounted seeders, rangeland type grass drill, mulch blowers and water tankers. A disc and seeder is the minimum equipment requirement.

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CALCULATION OF WORK RATING: Secondary formula.

VEGETATION SPRAYING

Consists of the application of chemicals to remove or control vegetation.

EQUIPMENT REQUIRED: Tanker truck with spraying equipment.

CALCULATION OF WORK RATING: Secondary formula. The contractor must have a commercial applicator license with the Illinois Department of Agriculture.

TREE TRIMMING AND SELECTIVE TREE REMOVAL

Consists of pruning trees, and selective removal of trees and tree stumps.

EQUIPMENT REQUIRED: Aerial equipment, brush chipper and stump grinder.

CALCULATION OF WORK RATING: Secondary formula.

FENCING

Consists of constructing chain link fence, wire fence and wood fence. This category is also applicable to the installation of object markers, delineators and mile post markers.

EQUIPMENT: Post hole auger equipment.

CALCULATION OF WORK RATING: Secondary formula.

GUARDRAIL

Consists of constructing steel plate beam guardrail, wood guardrail, cable road guard, posts (including guard posts), pipe handrail and metal railings. Removal of any of the aforementioned items or similar items is applicable to this work category.

EQUIPMENT REQUIRED: Post hammer or post hole auger.

CALCULATION OF WORK RATING: Secondary formula.

GROUTING

Consists of gunite construction, lime injection systems, clay grouting, chemical grouting, compaction grouting, cement grouting, jet grouting, asphalt grouting and bituminous or cement fly ash undersealing of concrete pavements. Applicable to soil stabilization and rehabilitation of dams, bridges, sewers, tanks, reservoirs, tunnels, culverts, walls, masonry structures, etc. This category is also applicable to mud jacking, slab jacking and various under-sealing projects.

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EQUIPMENT REQUIRED: Air compressor, mixing equipment, agitator-type reservoir tank and grout pump.

CALCULATION OF WORK RATING: Secondary formula.

PAINTING

Consists of the cleaning, containment and painting of metal surfaces. This includes structural steel, sign structures, sign supports, traffic signal hardware, lighting hardware, etc.

EQUIPMENT REQUIRED: Air compressor, sandblast equipment and paint spraying equipment.

CALCULATION OF WORK RATING: Secondary formula.

SIGNING

Consists of installing, relocating, renovating, refurbishing and cleaning sign panels. This category also includes the installation and relocation of sign supports and sign structures, installation of object markers, installation of delineators and installation of mile post markers. Removal of any of the aforementioned items is also applicable to this work category.

EQUIPMENT REQUIRED: Auger and aerial equipment. A crane will also meet minimum equipment requirements.

CALCULATION OF WORK RATING: Secondary formula.

PAINT PAVEMENT MARKING

Consists of the installation of paint pavement marking lines, letters and symbols.

EQUIPMENT REQUIRED: A truck mounted or hand operated painting equipment.

CALCULATION OF WORK RATING: Secondary formula.

THERMOPLASTIC PAVEMENT MARKING

Consists of the installation of thermoplastic pavement marking lines, letters and symbols.

EQUIPMENT REQUIRED: A truck mounted or hand operated equipment which is approved by the Bureau of Operations within the Division of Highways.

CALCULATION OF WORK RATING: Secondary formula.

EPOXY PAVEMENT MARKING

Consists of the installation of epoxy pavement marking lines, letters and symbols.

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EQUIPMENT REQUIRED: Equipment which is approved by the Bureau of Operations within the Division of Highways.

CALCULATION OF WORK RATING: Secondary formula.

INSTALLATION OF RAISED PAVEMENT MARKERS

Consists of the installation of raised reflective pavement markers and their removal.

EQUIPMENT REQUIRED: Plunge router or saw.

CALCULATION OF WORK RATING: Secondary formula.

PAVEMENT TEXTURING AND SURFACE REMOVAL

Consists of grooving or grinding PCC pavement or continuously reinforced PCC pavement.

EQUIPMENT REQUIRED: Grooving or grinding equipment.

CALCULATION OF WORK RATING: Secondary formula.

COLD MILLING, PLANING AND ROTOMILLING

Consists of bituminous surface removal or texturing bituminous pavements. Also applicable to pulverizing and mixing existing bituminous material.

EQUIPMENT REQUIRED: Milling, planing or grinding machine.

CALCULATION OF WORK RATING: Secondary formula.

ERECTION

Consists of erecting structural steel or sign trusses.

EQUIPMENT REQUIRED: Crane.

CALCULATION OF WORK RATING: Secondary formula.

DEMOLITION

Consists of the removal of timber, steel and concrete structures and buildings.

EQUIPMENT REQUIRED: Crane or excavator or front-end loader backhoe loader or bulldozer.

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CALCULATION OF WORK RATING: Secondary formula.

FABRICATION

Consists of fabricating, delivering and storing structural steel.

EQUIPMENT REQUIRED: Fabrication plant.

CALCULATION OF WORK RATING: Secondary formula. The contractor must be listed on the AISC Register of Certified Structural Steel Fabricators and have a Certification Category of I, II or III to fabricate main load carrying components.

TUNNEL EXCAVATION

Consists of earth and rock excavation for tunnels, and construction of liner plate shafts, steel sheeted shafts and wood sheeted shafts. This category also includes rock bolting and major boring and jacking of pipe-in-place.

EQUIPMENT REQUIRED: Tunnel boring machine.

CALCULATION OF WORK RATING: Secondary formula.

RAILROAD (TRACK) CONSTRUCTION

Consists of sub-ballast construction, ballast construction, installation of crossties and installation of steel rails.

EQUIPMENT REQUIRED: Ballast regulator, tamper and lifting equipment.

CALCULATION OF WORK RATING: Secondary formula.

EXPRESSWAY CLEANING

Consists of sweeping expressways and arterial routes.

EQUIPMENT REQUIRED: Motorized street sweeping equipment.

CALCULATION OF WORK RATING: Secondary formula.

MARINE CONSTRUCTION

Consists of the construction of harbors and docking facilities on lakes or rivers. This includes breakwater structures, groins, jetties, seawalls, major revetments (riprap, interlocking concrete blocks and cast-in-place concrete slabs), bulkheads, piers, wharves, fenders and dolphins. This work category is also applicable to excavation for structures (includes cofferdams, temporary cribs, etc.), piling (all types), de-watering, mechanical dredging, underwater inspection and underwater repair.

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EQUIPMENT REQUIRED: Barge and barge-mounted crane.

CALCULATION OF WORK RATING: Secondary formula.

HYDRAULIC DREDGING

Dredging of various waterways by the use of pumping equipment.

EQUIPMENT REQUIRED: Barge and pumping equipment.

CALCULATION OF WORK RATING: Secondary formula.

HOT (IN-PLACE) RECYCLING

A road construction technique that involves a single-pass or a two-pass operation which scarifies and rejuvenates the existing pavement material or combines existing pavement material with virgin material.

EQUIPMENT REQUIRED: Either a single recycle machine or a recycling train capable of heating, scarifying, remixing and relaying pavement material. Compaction equipment is also required.

CALCULATION OF WORK RATING: Secondary formula.

COLD (IN-PLACE) RECYCLING

A road construction technique that reuses existing pavement material.

EQUIPMENT REQUIRED: Emulsion tanker truck, recycle machine, paver and compaction equipment.

CALCULATION OF WORK RATING: Secondary formula.

DEPARTMENT OF TRANSPORTATION
NOTICE OF PROPOSED RULES

Section 650.APPENDIX B REQUEST FOR EXTENSION OF PREQUALIFICATION RATINGS

Engineer of Construction
Illinois Department of Transportation
2300 South Dirksen Parkway, Room 322
Springfield, IL 62764

Extension Letter
from the CPA (30 Day)

Dear _____:

Our client, (firm), requires a thirty (30) day extension of their prequalification ratings (include the reason for the extension).

Signature(s)

Engineer of Construction
Illinois Department of Transportation
2300 South Dirksen Parkway, Room 322
Springfield, IL 62764

Extension Letter
from the CPA (60 or 90 Day)

Dear _____:

Our client, (firm), requires a (sixty (60) or ninety (90)) day extension of their prequalification ratings (include the reason for the extension). Included is an adjusted trial balance sheet as of the audit date for your use.

Signature(s)

DEPARTMENT OF TRANSPORTATION

NOTICE OF PROPOSED RULES

Section 650.APPENDIX C FINANCIAL PLEDGE LETTERS

Engineer of Construction
 Illinois Department of Transportation
 2300 South Dirksen Parkway, Room 322
 Springfield, IL 62764

Individual Pledge to a Contractor
 with an Audited or Unaudited
 Financial Statement

Dear _____:

To improve the financial prequalification rating of (firm), (pledgor) pledge the following asset(s) to (firm) for the life of the (date of balance sheet) Contractor's Statement of Experience and Financial Condition.

If a bank account:

- A) Name of bank
- B) Location of bank
- C) Name of account holder(s)
- D) Amount
- E) Disclosure of any pledge
- (Example: A pledge against a Certificate of Deposit.)

If equipment:

- A) Description (i.e., make, model, year, serial number and size or capacity)
- B) Owner(s)
- C) Book or appraised value
- D) Disclosure of any encumbrance

If real estate:

- A) Description
 - B) Owner(s)
 - C) Book or appraised value
 - D) Disclosure of any encumbrance
- Note: Verification is required for bank accounts and investments involving contractors who are classified under unaudited status.

If other investments:

- A) Description
- B) Owner(s)
- C) Book or market value
- D) Disclosure of any pledge
- (Example: A pledge against a stock or bond.)

Signature(s) _____

Engineer of Construction
 Illinois Department of Transportation
 2300 South Dirksen Parkway, Room 322
 Springfield, IL 62764

Affiliated Company Pledge
 to a Contractor with
 an Audited or Unaudited
 Financial Statement

Dear _____:

To improve the financial prequalification rating of (firm), (pledgor) pledge the following assets of our financial statement to (firm) for the life of the (date of balance sheet) Contractor's Statement of Experience and Financial Condition.

Signature(s) _____

DEPARTMENT OF TRANSPORTATION

NOTICE OF PROPOSED RULES

Section 650.APPENDIX D FINANCIAL VERIFICATION LETTER

Engineer of Construction
 Illinois Department of Transportation
 2300 South Dirksen Parkway, Room 322
 Springfield, IL 62764

Verification Letter from the CPA.
 Required Only for an Individual
 Pledge to a Contractor with an
 Audited Financial Statement.

Dear _____:

Our client, (firm), has requested us to write this letter to verify the information below concerning asset(s) pledged by the officer(s) or director(s) or shareholder(s) or employee(s) of the firm in order to improve the financial prequalification rating of (firm) for their (date of balance sheet) Contractor's Statement of Experience and Financial Condition.

If a bank account:

- A) Name of bank
- B) Location of bank
- C) Name of account holder(s)
- D) Amount
- E) Disclosure of any pledge
- (Example: A pledge against a Certificate of deposit.)
- F) Method of verification

If equipment:

- A) Description (i.e., make, model, year, serial number and size or capacity)
- B) Owner(s)
- C) Book or appraised value
- D) Disclosure of any encumbrance
- E) Method of verification

If real estate:

- A) Description
- B) Owner(s)
- C) Book or appraised value
- D) Disclosure of any encumbrance
- E) Method of verification

If other investments:

- A) Description
- B) Owner(s)
- C) Book or market value
- D) Disclosure of any pledge
- (Example: A pledge against a stock or bond.)
- E) Method of verification

Signature(s) _____

DEPARTMENT OF TRANSPORTATION

NOTICE OF PROPOSED RULES

Section 650. APPENDIX E CORPORATE RESOLUTION

CORPORATE RESOLUTION

At a meeting held on _____ (date) at _____ (location),
the following was approved:

(Financial Pledge by An Affiliated Company)

(Pledgor) pledge the assets of our financial statement to (firm) for the life of the (date of balance sheet) Contractor's Statement of Experience and Financial Condition.

(Equipment Pledge)

(Pledgor) pledge the following equipment (list equipment) for the exclusive use of (Pledgee) for the life of the (date of balance sheet) Contractor's Statement of Experience and Financial Condition.

(Transfer of Financial or Work Rating)

(Transferor Firm) transfers _____ (amount) of its prequalification (indicate financial or work ratings) to (Transferee Firm) for the life of the (date of balance sheet) Contractor's Statement of Experience and Financial Condition. The (shareholder(s)) own (percent) of (Transferor Firm) and (percent) of (Transferee firm).

This Resolution was signed this date _____, 19____ at _____
Mo. Day (Location)

Signature(s) _____

Corporate Seal (Optional)

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENTS

1) HEADING OF THE PART: Sport Fishing Regulations for the Waters of Illinois

2) CODE CITATION: 17 Ill. Adm. Code 810

3) SECTION NUMBERS: ADOPTED ACTION:

810.10 Amendments
810.35 Amendments
810.37 Amendments
810.45 Amendments
810.70 Amendments

4) STATUTORY AUTHORITY: Implementing and authorized by Sections 1-120, 1-125, 1-150, 5-5, 10-5, 10-10, 10-15, 10-20, 10-25, 10-30, 10-35, 10-45, 10-50, 10-60, 10-75, 10-90, 10-95, 15-50, 20-5, 20-35 and 25-5 of the Fish and Aquatic Life Code (Ill. Rev. Stat. 1991, ch. 56, pars. 1-120, 1-125, 1-150, 5-5, 10-5, 10-10, 10-15, 10-20, 10-25, 10-30, 10-35, 10-45, 10-50, 10-60, 10-75, 10-90, 10-95, 15-50, 20-5, 20-35 and 25-5) [515 ILCS 5/1-120, 1-125, 1-150, 5-5, 10-5, 10-10, 10-15, 10-20, 10-25, 10-30, 10-35, 10-45, 10-50, 10-60, 10-75, 10-90, 10-95, 15-50, 20-5, 20-35 and 25-5]

5) EFFECTIVE DATE OF AMENDMENTS: FEB 23 1994

6) DOES THIS RULEMAKING CONTAIN AN AUTOMATIC REPEAL DATE? No

7) DO THESE AMENDMENTS CONTAIN INCORPORATIONS BY REFERENCE? No

8) DATE FILED IN AGENCY'S PRINCIPAL OFFICE: February 25, 1994

9) NOTICE OF PROPOSAL PUBLISHED IN ILLINOIS REGISTER: November 19, 1993, 17 Ill. Reg. 19785

10) HAS JC&R ISSUED A STATEMENT OF OBJECTIONS TO THESE RULES: No

11) DIFFERENCES BETWEEN PROPOSAL AND FINAL VERSION:

A new subsection 810.37(b)(35) was added:

35) Except that trotlines may be set within 300 feet from shore.

In Section 810.40, daily catch limits were added for the following:

Horseshoe Lake State Park

DEPARTMENT OF CONSERVATION
NOTICE OF ADOPTED AMENDMENTS

Madison County
(Unlawful to trespass upon designated waterfowl hunting areas during the 3 days prior to the waterfowl season)
All Fish - 2 Pole and Line Fishing Only (1)(35)
Large or Smallmouth Bass - 15" Minimum Length Limit
Large or Smallmouth Bass (14) - 3 Fish Daily Creel Limit
White, Black or Hybrid
Crappie (15) - 25 Fish Daily Creel Limit

In Section 810.45, the following sites were added:

- Lake Paradise, City of Mattoon
Coles County
- All Fish - 2 Pole and Line Fishing Only (1)
Large or Smallmouth Bass - 14" Minimum Length Limit
- Lake Paradise Shadow Ponds, City of Mattoon
Coles County
- All Fish - 2 Pole and Line Fishing Only (1)
Large or Smallmouth Bass - 14" Minimum Length Limit

In Section 810.45, the language for Sam Dale Trout Pond is new language and should have been underlined.

- 12) HAVE ALL THE CHANGES AGREED UPON BY THE AGENCY AND JCAR BEEN MADE AS INDICATED IN THE AGREEMENT LETTER ISSUED BY JCAR? Yes
- 13) WILL THESE AMENDMENTS REPLACE AN EMERGENCY RULE (AMENDMENT, REPEALER) CURRENTLY IN EFFECT? No
- 14) ARE THERE ANY AMENDMENTS PENDING ON THIS PART? No

15) SUMMARY AND PURPOSE OF AMENDMENTS: These amendments were based upon the results of biological surveys and subsequent data analyses. Amendments include updating statewide regulations and site specific regulations and providing 1994 dates for "Free Fishing Days".

16) INFORMATION AND QUESTIONS REGARDING THESE ADOPTED AMENDMENTS SHALL BE DIRECTED TO:

Jack Price
Department of Conservation
524 S. Second Street, Room 485
Springfield, IL 62701-1787

THE FULL TEXT OF THE ADOPTED AMENDMENTS BEGINS ON THE NEXT PAGE:

DEPARTMENT OF CONSERVATION
NOTICE OF ADOPTED AMENDMENT(S)

TITLE 17: CONSERVATION
CHAPTER 1: DEPARTMENT OF CONSERVATION
SUBCHAPTER b: FISH AND WILDLIFE
PART 810
SPORT FISHING REGULATIONS FOR THE WATERS OF ILLINOIS

Section	
810.10	Sale of Fish and Fishing Seasons
810.20	Snagging
810.30	Pole and Line Fishing Only (Repealed)
810.35	Statewide Sportfishing Regulations - Daily Catch and Size Limits
810.37	Definitions for Site Specific Sportfishing Regulations
810.40	Daily Catch and Size Limits (Repealed)
810.45	Site Specific Water Area Regulations
810.50	Bait Fishing
810.60	Bullfrogs
810.70	Free Fishing Days
810.80	Emergency Protective Regulations
810.90	Fishing Tournament Permit
810.100	Bed Protection

AUTHORITY: Implementing and authorized by Sections 1-120, 1-125, 1-150, 5-5, 10-5, 10-10, 10-12, 10-15, 10-20, 10-25, 10-30, 10-35, 10-45, 10-50, 10-60, 10-75, 10-90, 10-95, 15-50, 20-5, 20-35 and 25-5 of the Fish and Aquatic Life Code (Ill. Rev. Stat. 1991, ch. 56, pars. 1-120, 1-125, 1-150, 5-5, 10-5, 10-10, 10-12, 10-15, 10-20, 10-25, 10-30, 10-35, 10-45, 10-50, 10-60, 10-75, 10-90, 10-95, 15-50, 20-5, 20-35 and 25-5) (15 ILCS 5/1-120, 1-125, 1-150, 5-5, 10-5, 10-10, 10-12, 10-15, 10-20, 10-25, 10-30, 10-35, 10-45, 10-50, 10-60, 10-75, 10-90, 10-95, 15-50, 20-5, 20-35 and 25-5).

SOURCE: Adopted at 5 Ill. Reg. 751, effective January 8, 1981; codified at 5 Ill. Reg. 10647; amended at 6 Ill. Reg. 342, effective December 23, 1981; amended at 6 Ill. Reg. 7411, effective June 11, 1982; amended at 7 Ill. Reg. 209, effective December 22, 1982; amended at 8 Ill. Reg. 1564, effective January 23, 1984; amended at 8 Ill. Reg. 16769, effective August 10, 1984; amended at 9 Ill. Reg. 2916, effective February 26, 1985; emergency amendments at 9 Ill. Reg. 3825, effective March 13, 1985, for a maximum of 150 days; emergency expired August 10, 1985; amended at 9 Ill. Reg. 6181, effective April 24, 1985; amended at 9 Ill. Reg. 14291, effective September 5, 1985; amended at 10 Ill. Reg. 4835, effective March 6, 1986; amended at 11 Ill. Reg. 4638, effective March 10, 1987; amended at 12 Ill. Reg. 5306, effective March 8, 1988; emergency amendments at 12 Ill. Reg. 6981, effective April 4, 1988, for a maximum of 150 days; emergency expired September 1, 1988; emergency amendments at 12 Ill. Reg. 10525, effective June 7, 1988, for a maximum of 150 days; emergency expired November 4, 1988; amended at 12 Ill. Reg. 15982, effective September 27, 1988; amended at 13 Ill. Reg. 8419, effective May 19, 1989; emergency amendments at 13 Ill. Reg. 12643, effective July 14, 1989, for a maximum of 150 days; emergency expired December 11, 1989; emergency amendments

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at 13 Ill. Reg. 14085, effective September 4, 1989, for a maximum of 150 days; emergency expired February 1, 1990; emergency amendments at 13 Ill. Reg. 15118, effective September 11, 1989, for a maximum of 150 days, emergency expired February 8, 1990; amended at 14 Ill. Reg. 6164, effective April 17, 1990; emergency amendments at 14 Ill. Reg. 6865, effective April 17, 1990, for a maximum of 150 days; emergency expired September 19, 1990; amended at 14 Ill. Reg. 8588, effective May 21, 1990; amended at 14 Ill. Reg. 16863, effective October 1, 1990; amended at 15 Ill. Reg. 4639, effective March 18, 1991; emergency amendments at 15 Ill. Reg. 5430, effective March 27, 1991, for a maximum of 150 days; emergency expired August 24, 1991; amended at 15 Ill. Reg. 9977, effective June 24, 1991; amended at 15 Ill. Reg. 13347, effective September 3, 1991; amended at 16 Ill. Reg. 5267, effective March 20, 1992; emergency amendments at 16 Ill. Reg. 6016, effective March 25, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 12526, effective July 28, 1992; amended at 17 Ill. Reg. 3853, effective March 15, 1993; emergency amendment at 17 Ill. Reg. 5915, effective March 25, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 10806, effective July 1, 1993; amended at 18 Ill. Reg. , effective FEB 28 1994.

Section 810.10 Sale of Fish and Fishing Seasons

- a) No fish or parts thereof (including eggs) taken by sport fishing methods (including snagging) may be bought, sold or bartered.
- b) Lake Michigan - The sport fishing season for rainbow smelt shall be from March 1 to April 30.
- c) It is unlawful to fish within 250 yards of an occupied duck or goose blind on Department-owned or -managed sites during the migratory waterfowl season.

(Source: Amended at 18 Ill. Reg. _____, effective FEB 28 1994.)

Section 810.35 Statewide Sportfishing Regulations - Daily Catch and Size Limits

- a) Length is measured from the tip of the snout to the end of the tail with the fish laid flat on a ruler, with the mouth of the fish closed and the tail lobes pressed together.
- b) No person may remove the head or tail of fishes to which length limits apply white on the waters to which length limits apply. No fish species may be dressed (fileted or head and tail removed) on any waters to which length limits are applicable. Regardless of where taken, no fish less than the specified minimum length or more than the daily catch shall be possessed on the waters to which length limits and/or daily catch limits apply.
- c) Statewide limits by type of fish:
 - 1) CHANNEL CATFISH

There are no daily catch or size limits except in those waters listed under Site Specific Regulations.

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- 2) LARGemouth BASS, SMALLmouth BASS, SPOTTED BASS
Daily catch limit is 6 bass, either singly or in the aggregate, except as specified under Site Specific Regulations. There is no size limit except in those waters listed under Site Specific Regulations.
- 3) MUSKELLUNGE, NORTHERN PIKE AND THEIR HYBRIDS
A) All muskellunge and muskellunge hybrids (tiger muskie) taken must be 30 inches in total length or longer, except as specified under Site Specific Regulations.
B) No more than 1 muskellunge or muskellunge hybrid (tiger muskie), either singly or in the aggregate, may be taken per day, except as specified under Site Specific Regulations.
C) All northern pike taken must be 24 inches in total length or longer, except in the Mississippi River and Ohio River where there is no size limit.
D) No more than 3 northern pike may be taken per day, except as specified under Site Specific Regulations.
- 4) CRAPPIE (WHITE, BLACK OR HYBRID CRAPPIE)
There are no catch or size limits except in those waters listed under Site Specific Regulations.
- 5) BLUEGILL AND REDEAR SUNFISH
There are no catch or size limits except in those waters listed under Site Specific Regulations.
- 6) STRIPED BASS (OCEAN ROCKFISH), WHITE BASS AND CYBRIDS
There are no daily catch limits or minimum size limits for striped bass (ocean rockfish), white bass, and their hybrids, which are less than 17 inches in total length, except in those waters listed under Site Specific Regulations. For these fish 17 inches in total length or longer, the daily limit is 3 fish, either singly or in the aggregate.
- 7) TROUT AND SALMON
Daily catch limit is 5 trout or salmon, either singly or in the aggregate.
- 8) WALLEYE, SAUGER OR THEIR HYBRID
Daily catch limit is 6 walleye, sauger or their hybrid, either singly or in the aggregate, except in those waters listed under Site Specific Regulations. There is no size limit except in those waters listed under Site Specific Regulations.

(Source: Amended 18 Ill. Reg. _____, effective FEB 28 1994.)

Section 810.37 Definitions for Site Specific Sportfishing Regulations

- a) Site Specific Regulations are listed by water area affected. The coverage of the regulation is dictated by the extent of the water area listed and not by the county. In some cases, regulations for a given water area or site may extend beyond the county(ies) listed. The county(ies) listed refer to the location of the dam or outfall for

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impoundments or mouths of small streams. Since large rivers or streams usually flow through many counties, the term "Multiple" is used rather than listing all counties where the large stream or river flows.

- b) The subsections listed below are referred to by number in Section 810.45. Each water area listed in Section 810.45 has numbers in parentheses which explain all of the definitions in this Section which apply to that water area.

1) Anglers must not use more than 2 poles and each pole must not have more than 2 hooks or lures attached while fishing, except that legal size cast nets, (in accordance with subsection 810.50(a)(1)) shad scoops, and minnow seines may be used to obtain shad, minnows, and crayfish to use as bait, provided that they are not sold.

2) Includes white, black, or hybrid crappie, singly or in the aggregate.

3) All largemouth and smallmouth bass taken must be less than 12 inches in total length or greater than 15 inches in total length.

4) Except that sport fishermen shall be allowed to use trotlines and jugs, and except that the use and aid of underwater breathing devices is prohibited. West of Wolf Creek Road, fishing from boats is permitted all year. Trotlines/jugs must be removed from boats until sunset from Memorial Day through Labor Day. East of Wolf Creek Road, fishing from boats is permitted from March 15 through September 30. Fishing from the bank is permitted all year only at the Wolf Creek and Route 148 causeways. On the entire lake, jugs and trotlines must be checked daily and must be removed on the last day they are used. It is illegal to use stakes to anchor any trotlines; they must be anchored only with portable weights and must be removed on the last day they are used. The taking of carp and buffalo with bow and arrow is permissible.

5) Except that carp, buffalo, and bowfin may be taken by pitchfork, bow and arrow devices, and gigs.

6) Including the Fox River south of the Illinois-Wisconsin line to the McHenry Dam.

7) Except that carp, buffalo, suckers and gar may be taken by bow and arrow devices or spears during May and June.

8) Except that sport fishermen may take carp by means of pitchfork, bow and arrow devices and gigs during May and June.

9) Except that ~~all fishing is prohibited in any area from Monday's Bridge upstream to the state property line east of headquarters, and in an area from a point 300' upstream of trail marker 47 upstream to trail marker 4.~~ Catch and Release ~~fishing only means that fish (all or identified species) caught must be immediately released alive and in good condition back into the water from which it came.~~

10) It shall be illegal to process trout during the period of October 1 to 5 a.m. on the third Saturday in October (both dates inclusive) which were taken during that period.

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

11) It shall be illegal to possess trout during the period of March 15 to 5 a.m. on the 1st Saturday in April (both dates inclusive) which were taken during that period.

12) Daily catch limit for largemouth or smallmouth bass, singly or in the aggregate, shall not exceed 6 fish per day, no more than one of which shall be greater than 15 inches in length and none of which shall be greater than 12 inches and less than or equal to 15 inches in length.

13) Except that jug fishing is permitted from the hours of sunset to sunrise, and except that carp and buffalo may be taken by bow and arrow devices from May 1 through September 30. All jugs must have owner's/user's name and complete address affixed.

14) Daily catch limit includes all fish species (either singly or in the aggregate) caught within each of the following fish groupings.

A) Largemouth or Smallmouth Bass

B) Walleye, Sauger, or their hybrid

C) Bluegill or Redear Sunfish

15) Daily catch limit includes white, black, or hybrid crappie either singly or in the aggregate.

16) Daily catch limit includes Striped Bass, White Bass and Hybrid Striped Bass either singly or in the aggregate.

17) Daily catch limit shall not exceed 10 fish daily, no more than 3 of which may be 17 inches or longer in length.

18) Except that sport fishermen shall be allowed to use trout lines, jugs and bank poles in the portions of the lake that lie north of the Davenport Bridge and northeast of the Parnell Bridge.

19) Except that sport fishermen may take carp, buffalo, gar, and bowfin by means of pitchfork and bow and arrow devices.

20) Carlyle Lake (including its tributary streams and those portions of the Kaskaskia River and Hurricane Creek up the U.S. Army Corps of Engineers Carlyle Lake Project boundaries), U.S. Army Corps of Engineers Bond, Clinton, and Fayette Counties.

21) Lake Shelbyville (including its tributary streams and those portions of the West Okaw and Kaskaskia Rivers up to Lake Shelbyville Project boundaries), Lake Shelbyville Project Ponds and Woods Lake, U.S. Army Corps of Engineers, Shelby and Moultrie Counties.

22) Rend Lake (including its tributary streams and those portions of the Big Muddy and Casey Fork Rivers up to the Rend Lake Project boundaries), Rend Lake Project Ponds, U.S. Army Corps of Engineers, Franklin and Jefferson Counties.

23) Lake Vermillion and the portion of the North Fork of the Vermillion River between the Lake Vermillion Dam and the Interstate Water Company's Pump Station Spillway, Vermillion County Conservation District, Vermillion County.

24) 10 Fish Daily Creel Limit of which no more than 6 may be walleye.

25) Daily catch limit for largemouth or smallmouth bass, singly or in the aggregate, shall not exceed 3 fish per day, no more than one

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of which may be equal to or greater than 15 inches in total length and no more than 2 of which may be less than 15 inches in total length.

26) Lake Vermilion - Trot line and jug finishing allowed north of Boiling Springs Road.

27) Except that bank fishing is prohibited. Boat fishing is permitted from the next to last Saturday in April until the second Sunday in October, during the hours of 6:00 a.m. to 10:00 a.m. and 3:00 p.m. to 8:00 p.m.

28) Except that carp, carpsuckers, buffalo, gar, bowfin, and suckers may be taken by means of pitchfork, gigs, bow and arrow or bow and arrow devices.

29) Except that carp, buffalo, suckers and carpsuckers may be taken by means of pitchfork and gigs (no bow and arrow devices).

30) Fishing is permitted from March 15 through September 30, both dates inclusive, from sunrise to sunset. Fishing during all other times of the year is illegal and not permitted.

31) Daily catch limit for largemouth or smallmouth bass, singly or in the aggregate, shall not exceed 3 fish daily, no more than one of which may be equal to or greater than 15 inches in total length and no more than 2 of which may be less than 12 inches in total length.

32) Daily catch limit includes Striped Bass, White Bass, Yellow Bass and Hybrid Striped Bass, either singly or in the aggregate, no more than 4 of which may be 15 inches or longer in length.

33) Daily catch limit includes Striped Bass, White Bass, Yellow Bass and Hybrid Striped Bass either singly or in the aggregate.

34) No fishing within 250 yards of an occupied blind (within the hunting area) on all Department-owned or managed sites.

35) Except that trotlines may be set within 300 feet from shore.

(Source: Amended at 18 Ill. Reg. _____, effective _____, FEB 23 1994)

Section 810.45 Site Specific Water Area Regulations

Fishing regulations, including species of fish, fishing methods and daily catch limits are listed for each water area. The numbers in parenthesis refer to the corresponding numbered definitions in Section 810.37 of this Part. If a water area is not listed or if a specific species is not listed, then state-wide restrictions apply. Check the bulletin boards at the specific site for any emergency changes to regulations.

Allison Lake, City of Allison

Logan County

All Fish

Channel Catfish

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Anderson Lake Fish and Wildlife Area

DEPARTMENT OF CONSERVATION

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Fulton County
(Unlawful to trespass upon designated waterfowl hunting areas 7 days prior to the waterfowl season and on areas designated as waterfowl refuges from October 10 until the end of the waterfowl season)

Andover Lake, City of Andover

Henry County

All Fish

Channel Catfish

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Apple River (within the boundaries of Apple River Canyon State Park)

Jo Daviess County

Smallmouth Bass

Smallmouth Bass

Trout

- 14" Minimum Length Limit
- 1 Fish Daily Creel Limit
- Spring Closed Season (11)

Argyle Lake, Argyle Lake State Park

McDonough County

All Fish

Channel Catfish

Large or Smallmouth Bass (14)

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 1 Fish more than 15" and/or 5 less than 12" Daily (12)
- Fall Closed Season (10)
- 14" Minimum Length Limit

Trout

Walleye, Sauger or Hybrid

Walleye

Ashland City Reservoir, City of Ashland

Cass County

All Fish

Channel Catfish

Large or Smallmouth Bass

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 15" Minimum Length Limit

Ashley Reservoir, City of Ashley

Washington County

All Fish

Channel Catfish

Large or Smallmouth Bass

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 15" Minimum Length

Auburn Park Lagoon, Chicago Park District

Cook County

All Fish

Channel Catfish

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Axehead Lake, Cook County Forest Preserve

Cook County

Trout

- Fall Closed Season (10)

Baker Lake, City of Peru

THE CHICAGO TRIBUNE
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- LaSalle County
- All Fish
 - 2 Pole and Line Fishing Only (1)
 - 10 Fish Daily Creel Limit
 - 6 Fish Daily Creel Limit
 - Channel Catfish
 - 14" Minimum Length Limit
 - Large or Smallmouth Bass (14)
 - 1 Fish Daily Creel Limit
- Baldwin Lake, Baldwin Lake Conservation Area
- Randolph County
- All Fish
 - 2 Pole and Line Fishing Only (1)(28)
 - 18" Minimum Length Limit
 - 17" Minimum Length Limit
 - 3 Fish Daily Creel Limit
 - 25 Fish Daily Creel Limit
 - 9" Minimum Length Limit
- Banana Lake, Lake County Forest Preserve District
- Lake County
- All Fish
 - 2 Pole and Line Fishing Only (1)
 - 6 Fish Daily Creel Limit
 - 1 Fish Daily Creel Limit
 - 15" Minimum Length Limit
 - Fall Closed Season (10)
- Banner Marsh Lake & Ponds, Banner Marsh State Fish and Wildlife Area
- Peoria/Fulton Counties
- All Fish
 - 2 Pole and Line Fishing Only (1)(7)
 - 6 Fish Daily Creel Limit
 - 1 Fish Daily Creel Limit
 - 14" Minimum Length Limit
 - 14" Minimum Length Limit
- Batchtown Wildlife Management Area
- Calhoun County
- (Unlawful to trespass upon designated waterfowl hunting areas during the 3 days prior to the waterfowl season)
- Baumann Park Lake, City of Cherry Valley
- Winnebago County
- All Fish
 - 2 Pole and Line Fishing Only (1)
 - 6 Fish Daily Creel Limit
 - 14" Minimum Length Limit
 - 1 Fish Daily Creel Limit

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ILLINOIS REGISTER

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

- Bay-Creek-Lakey-U-S-Forest-Service
- Pope-County
- All Fish
 - 2 Pole and Line Fishing Only (1)
 - 6 Fish Daily Creel Limit
 - 15" Minimum Length Limit
 - Fall Closed Season (10)
- Beall Woods Lake, Beall Woods Conservation Area
- Wabash County
- All Fish
 - 2 Pole and Line Fishing Only (1)
 - 6 Fish Daily Creel Limit
 - 15" Minimum Length Limit
 - Fall Closed Season (10)
- Beaver Dam Lake, Beaver Dam State Park
- Macoupin County
- All Fish
 - 2 Pole and Line Fishing Only (1)
 - 25 Fish Daily Creel Limit
 - 6 Fish Daily Creel Limit
 - 15" Minimum Length Limit
 - 3 Fish Daily Creel Limit
 - Fall Closed Season (10)
- Beck Lake, Cook County Forest Preserve District
- Cook County
- All Fish
 - 2 Pole and Line Fishing Only (1)
 - 6 Fish Daily Creel Limit
 - 18" Minimum Length Limit
- Bellevue Lake, Cook County Forest Preserve District
- Cook County
- Trout
 - Fall Closed Season (10)
- Bird Park Quarry, City of Kankakee
- Kankakee County
- Trout
 - Fall Closed Season (10)
 - Spring Closed Season (11)
- Borah Lake, City of Olney
- Richland County
- All Fish
 - 2 Pole and Line Fishing Only (1)
 - 6 Fish Daily Creel Limit
 - 14" Minimum Length Limit

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

Boston Pond, Stephen A. Forbes State Park

Marion County

Trout

Trout

- Fall Closed Season (10)

- Spring Closed Season (11)

Braidwood-Mazonia Lakes and Ponds, Mazonia-Braidwood State Fish and Wildlife Area

Grundy/Will County

(Unlawful to fish or trespass upon the designated waterfowl hunting areas or refuge beginning 2 weeks prior to the waterfowl season until the end of the waterfowl season at Mazonia Fish and Wildlife Area. Braidwood Lake is closed to all fishing and boat traffic from 2 weeks prior to duck season through the day before duck season and is closed to all fishing during waterfowl season commencing with duck season)

All Fish

Channel Catfish

- 2 Pole and Line Fishing Only (1)

- 6 Fish Daily Creel Limit

- 15" Minimum Length Limit

- 3 Fish Daily Creel Limit

Large or Smallmouth Bass (14)

Striped, White, or Hybrid

Striped Bass

Striped, White, or Hybrid

- 3 Fish Daily Creel Limit

Striped Bass (16)

Walleye, Sauger, or Hybrid

- 14" Minimum Length Limit

Walleye

White, Black, or Hybrid

- 10 Fish Daily Creel Limit

Crappie (15)

Buckner City Reservoir, City of Buckner

Franklin County

All Fish

Channel Catfish

- 2 Pole and Line Fishing Only (1)

- 6 Fish Daily Creel Limit

Bunker Hill Lake, City of Bunker Hill

Macoupin County

All Fish

Channel Catfish

- 2 Pole and Line Fishing Only (1)

- 6 Fish Daily Creel Limit

Burrells Wood Park Pond

White County

Channel Catfish

- 6 Fish Daily Creel Limit

Busse Lake, Cook County Forest Preserve

Cook County

All Fish

Channel Catfish

Large or Smallmouth Bass

Walleye, Sauger, or Hybrid

- 2 Pole and Line Fishing Only (1)

- 6 Fish Daily Creel Limit

- 14" Minimum Length Limit

- 16" 18" Minimum Length Limit

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

Calhoun Point Wildlife Management Area

Calhoun County

(Unlawful to trespass upon designated waterfowl hunting areas during the 3 days prior to the waterfowl season)

Campus Pond - Eastern Illinois University, State of

Illinois

Coles County

Trout

Trout

- Fall Closed Season (10)

- Spring Closed Season (11)

Canton Lake, City of Canton

Fulton County

All Fish

Channel Catfish

Large or Smallmouth Bass

Large or Smallmouth Bass (16)

- 2 Pole and Line Fishing Only (1)

- 6 Fish Daily Creel Limit

- 15" Minimum Length Limit

- 3 Fish Daily Creel Limit

Carlyle Lake (20), U.S. Army Corps of Engineers

Clinton County

(Unlawful to enter subimpoundment area during the 3 days prior to the opening of waterfowl hunting season. No one may enter the subimpoundment area before 4:30 a.m. each day of the waterfowl hunting season and no one may remain in the area after 3:00 p.m. each day of the waterfowl hunting season)

Large or Smallmouth Bass

Walleye, Sauger, or Hybrid

Walleye

White, Black, or Hybrid

Crappie (15)

White, Black, or Hybrid

Crappie

- 14" Minimum Length Limit

- 14" Minimum Length Limit

- 10 Fish Daily Creel Limit

- 10" Minimum Length Limit

Carthage Lake, City of Carthage

Hancock County

Channel Catfish

- 6 Fish Daily Creel Limit

Cave-in-Rock State Park Pond, Cave-in-Rock State Park

Hardin County

Trout

Trout

- Fall Closed Season (10)

- Spring Closed Season (11)

Cedar Lake, U.S. Forest Service and City of Carbondale

Jackson County

All Fish

Large or Smallmouth Bass

Striped, White, or Hybrid

Striped Bass

Striped, White, or Hybrid

Striped Bass (16)

- 2 Pole and Line Fishing Only (1)

- 15" Minimum Length Limit

- 17" Minimum Length Limit

- 3 Fish Daily Creel Limit

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

Walleye, Sauger, or Hybrid
Walleye
- 14" Minimum Length Limit

Centralia Lake, City of Centralia
Marion County
Large or Smallmouth Bass
- 15" Minimum Length Limit

Charleston Lower Channel Lake, City of Charleston
Coles County
All Fish
- 2 Pole and Line Fishing Only (1)

Charleston Side Channel Lake, City of Charleston
Coles County
All Fish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit

Channel Catfish
Large or Smallmouth Bass
Striped, White, or Hybrid
Striped Bass
- 17" Minimum Length Limit
Striped, White, or Hybrid
Striped Bass (16)
- 3 Fish Daily Creel Limit

Charlie Brown Lake & Pond, City of Flora
Clay County
All Fish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit

Channel Catfish
Large or Smallmouth Bass

Citizen's Lake, State of Illinois
Warren County
All Fish
- 2 Pole and Line Fishing Only (1)
- 10 Fish Daily Creel Limit
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit
- 3 Fish Daily Creel Limit
- Fall Closed Season (10)
Trout
Trout

Bluegill or Redear Sunfish (14)
Channel Catfish
Large or Smallmouth Bass
Large or Smallmouth Bass (14)
Trout

Clear Lake, Kickapoo State Park
Vermillion County
Trout
Trout

- Fall Closed Season (10)
- Spring Closed Season (11)

Clinton Lake, Clinton Lake State Recreation Area
DeWitt County
All Fish
- 2 Pole and Line Fishing Only (1)(18)
- 14" Minimum Length Limit
- 17" Minimum Length Limit

Large or Smallmouth Bass
Striped, White, or Hybrid
Striped Bass
Striped, White, or Hybrid

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

Striped Bass (16)
Walleye or Sauger
White, Black, or Hybrid
Crappie (15)
White, Black, or Hybrid
Crappie
- 3 Fish Daily Creel Limit
- 14" Minimum Length Limit
- 15 Fish Daily Creel Limit
- 10" 9" Minimum Length Limit

East-Creek-Fish-and-Wildlife-Area, State of Illinois
Bureau County
All Fish
- 2 Pole and Line Fishing Only (1)
- 10 Fish Daily Creel Limit
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit
- 3 Fish Daily Creel Limit

Bluegill or Redear Sunfish (14)
Channel Catfish
Large or Smallmouth Bass
Large or Smallmouth Bass (14)
White, Black, or Hybrid
Crappie (15)
White, Black, or Hybrid
Crappie
- 15" Minimum Length Limit
- 3 Fish Daily Creel Limit
- 10 Fish Daily Creel Limit
- 9" Minimum Length Limit

Coffee Lake, Coffee Lake State Fish and Wildlife Area
Montgomery County
Large or Smallmouth Bass
Large or Smallmouth Bass (14)
White, Black, or Hybrid
Crappie (15)
White, Black, or Hybrid
Crappie
- 15" Minimum Length Limit
- 3 Fish Daily Creel Limit
- 10 Fish Daily Creel Limit
- 9" Minimum Length Limit

Coles County Airport Lake, Coles County Airport
Coles County
All Fish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit

Channel Catfish
Large or Smallmouth Bass

Cole's Trout Pond, State of Illinois
Whiteside County
Trout
Trout

- Fall Closed Season (10)
- Spring Closed Season (11)

Columbus Park Lagoon, Chicago Park District
Cook County
All Fish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Channel Catfish

Cook Co. F.P.D. Lakes, Cook County Forest Preserve District
Cook County
All Fish
- 2 Pole and Line Fishing Only (1)
- 14" Minimum Length Limit

Large or Smallmouth Bass

Coulterville City Lake, City of Coulterville
Randolph County
All Fish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Channel Catfish

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

Crab Orchard National Wildlife Refuge— Crab Orchard Lake, U.S. Fish and
Williamson County

- All Fish
- Striped, White, or Hybrid
- Striped Bass (16)
- 2 Pole and Line Fishing Only (1)(4)
- 10 Creel/3 Fish 17" or Longer Daily (17)
- 15" Minimum Length Limit
- Large or Smallmouth Bass

Crab Orchard National Wildlife Refuge— Devil's Kitchen Lake, U.S. Fish and
Williamson County

- All Fish
- 2 Pole and Line Fishing Only (1)

Crab Orchard National Wildlife Refuge— Little Grassy Lake, U.S. Fish and
Williamson County

- All Fish
- Channel Catfish
- Large or Smallmouth Bass
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 12-15" Slot Length Limit (3)

Crab Orchard National Wildlife Refuge: Refuge Ponds (except Visitor
Pond),

U.S. Fish and Wildlife Service
Williamson County

- All Fish
- Large or Smallmouth Bass
- 2 Pole and Line Fishing Only (1)
- 15" Minimum Length Limit

Crab Orchard National Wildlife Refuge: Visitor Pond, U.S. Fish and Wildlife
Service

Williamson County

- All Fish (30)
- Large or Smallmouth Bass
- 2 Pole and Line Fishing Only (1)
- 21" Minimum Length Limit

Crawford Co. Cons. Area - Picnic Pond, Crawford County Conservation Area
Crawford County

Trout

- Fall Closed Season (10)

Crawford Co. Cons. Area ponds, Crawford County Conservation Area
Crawford County

- All Fish
- Channel Catfish
- Large or Smallmouth Bass
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 15" Minimum Length Limit

Cull Impoundment Wildlife Management Area
Jersey County

(Unlawful to trespass upon designated waterfowl hunting areas 7 days prior to
the waterfowl season and on areas designated as waterfowl refuges from October
10 until the end of the waterfowl season)

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

Dawson Lake & Park Ponds, Moraine View State Park
McLean County

- All Fish
- Bluegill or Redear Sunfish (14)
- Channel Catfish
- Large or Smallmouth Bass
- Walleye, Sauger, or Hybrid
- Walleye
- White, Black or Hybrid Crappie
- White, Black or Hybrid
- Crappie (15)
- 2 Pole and Line Fishing Only (1)
- 25 Fish Daily Creel Limit
- 6 Fish Daily Creel Limit
- 15" Minimum Length Limit
- 14" Minimum Length Limit
- 9" Minimum Length Limit
- 15 Fish Daily Creel Limit

Decatur Park Dist. Ponds, City of Decatur
Macon County

- All Fish
- Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Defiance Lake, Moraine Hills State Park
McHenry County

- All Fish
- Channel Catfish
- Large or Smallmouth Bass
- Large or Smallmouth Bass (14)
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit
- 3 Fish Daily Creel Limit

Dixon Springs Ag. Center Pond; Dixon Springs Ag. Center

Pope County

Trout

- Fall Closed Season (10)
- Spring Closed Season (11)

Dolan Lake, Hamilton County Conservation Area

Hamilton County

- All Fish
- Channel Catfish
- Large or Smallmouth Bass
- Walleye, Sauger, or Hybrid
- Walleye
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit
- 14" Minimum Length Limit

Douglas Park Lagoons, Chicago Park District
Cook County

- All Fish
- Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Butchman Lake, Shawnee National Forest

Johnson County

All Fish

Channel Catfish

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

East Fork Lake, City of Olney

Richland County

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

- All Fish
Channel Catfish
Large or Smallmouth Bass
Minimum Length Limit
Walleye, Sauger, or Hybrid
Walleye
White, Black, or Hybrid
Crappie (15)
Evergreen Lake, City of Bloomington
McLean County
Large or Smallmouth Bass
Pure Muskellunge
Walleye, Sauger, or Hybrid
Walleye
Faries Park Pond, City of Decatur
Macon County
Trout
Ferne Clyffe Lake, Ferne Clyffe State Park
Johnson County
All Fish
Channel Catfish
Trout
Trout
Forbes State Lake, Stephen A. Forbes State Park
Marion County
Striped, White, or Hybrid
Striped Bass
Striped, White, or Hybrid
Striped Bass (16)
Walleye, Sauger, or Hybrid
Walleye
Forbes State Lake-Park Ponds, Stephen A. Forbes State Park
Marion County
All Fish
Channel Catfish
Large or Smallmouth Bass
Forest Park Lagoon, City of Shelbyville
Shelby County
All Fish
Channel Catfish
Trout
Trout
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 12-15" Spot-length limit-10-15" Minimum Length Limit
- 14" Minimum Length Limit
- 25 Fish Daily Creel Limit
- 15" Minimum Length Limit
- 35" Minimum Length Limit
- 14" Minimum Length Limit
- Fall Closed Season (10)
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- Fall Closed Season (10)
- Spring Closed Season (11)
- 17" Minimum Length Limit
- 3 Fish Daily Creel Limit
- 14" Minimum Length Limit
- 2 Pole and Line Fishing Only (1)(5)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- Fall Closed Season (10)
- Spring Closed Season (11)

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

- Four Lakes, Winnebago County Forest Preserve
Winnebago County
All Fish
Channel Catfish
Fox Chain O'Lakes, State of Illinois
Lake and McHenry Counties
Large or Smallmouth Bass
Pure Muskellunge
Walleye, Sauger, or Hybrid
Walleye
Walleye, Sauger, or Hybrid
Walleye (14)
Frank Holten Lakes, Frank Holten State Park
St. Clair County
All Fish
Channel Catfish
Large or Smallmouth Bass
Trout
Trout
Franklin Creek, Franklin Creek State Natural Area
Lee County
All Fish
- 2 Pole and Line Fishing Only (1)(9)
Gale Lake, Village of East Galesburg
Knox County
All Fish
Bluegill or Redear Sunfish (14)
Channel Catfish
Large or Smallmouth Bass
Large or Smallmouth Bass (14)
Garfield Park Lagoon, Chicago Park District
Cook County
All Fish
Channel Catfish
Gebhard Woods Ponds, Gebhard Woods State Park
Grundy County
All Fish
Trout
Giant City Park Ponds, State of Illinois
Jackson and Union Counties
Largemouth and Spotted Bass
15" Minimum Length Limit
Gillespie New City Lake, City of Gillespie
- 2 Pole and Line Fishing Only (1)
- Spring Closed Season (11)
- 15" Minimum Length Limit

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

Macoupin County

- Channel Catfish
- Large or Smallmouth Bass
- Large or Smallmouth Bass (14)
- 6 Fish Daily Creel Limit
- 12-15" Slot Length Limit (3)
- 3 Fish Daily Creel Limit

Gillespie Old City Lake, City of Gillespie

- Macoupin County
- All Fish
- Channel Catfish
- Large or Smallmouth Bass
- Large or Smallmouth Bass (14)
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 15" Minimum Length Limit
- 3 Fish Daily Creel Limit

Glades - 12 Mile Island Wildlife Management Area

Jersey County
(Unlawful to trespass upon designated waterfowl hunting areas during the 3 days prior to the waterfowl season)

Gladstone Lake, Henderson County Conservation Area

- Henderson County
- All Fish
- Bluegill or Redear Sunfish (14)
- Channel Catfish
- Large or Smallmouth Bass
- Large or Smallmouth Bass (14)
- 2 Pole and Line Fishing Only (1)
- 10 Fish Daily Creel Limit
- 6 Fish Daily Creel Limit
- 12-15" Slot Length Limit (3)
- 3 Fish Daily Creel Limit

Glen Shoals Lake, City of Hillsboro

- Montgomery County
- Large or Smallmouth Bass
- Large or Smallmouth Bass (14)
- Striped, White, or Hybrid
- Striped Bass
- Striped, White, or Hybrid
- Striped Bass (16)
- 15" Minimum Length Limit
- 3 Fish Daily Creel Limit
- 17" Minimum Length Limit
- 3 Fish Daily Creel Limit

Gudar-Diamond/Hurricane Island Wildlife Management Area, Calhoun County

(Unlawful to trespass upon designated waterfowl hunting areas 7 days prior to the waterfowl season and on areas designated as waterfowl refuges from October 10 until the end of the waterfowl season)

Gompers Park Lagoon, Chicago Park District

- Cook County
- All Fish
- Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Gordon F. More Park Lake, City of Alton

- Madison County
- All Fish
- Bluegill or Redear Sunfish (14)
- Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 25 Fish Daily Creel Limit
- 6 Fish Daily Creel Limit

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

- Large or Smallmouth Bass (14)
- 2 Fish <15" &/or 1 Fish >or= 15" Daily (25)

Governor Bond Lake, City of Greenville

- Bond County
- Large or Smallmouth Bass
- Large or Smallmouth Bass (14)
- Striped, White, or Hybrid
- Striped Bass
- Striped, White, or Hybrid
- Striped Bass (16)
- 15" Minimum Length Limit
- 3 Fish Daily Creel Limit
- 17" Minimum Length Limit
- 3 Fish Daily Creel Limit

Greenfield City Lake, City of Greenfield

- Green County
- All Fish
- Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Greenville Old City Lake, City of Greenville

- Bond County
- All Fish
- Channel Catfish
- Trout
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- Fall Closed Season (10)

Harrisburg New City Reservoir, City of Harrisburg

- Saline County
- All Fish
- Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Heidecke Lake, Heidecke Lake State Fish and Wildlife Area

Grundy County
(Shall be closed to all fishing and boat traffic except for legal waterfowl hunters from 2 weeks prior to duck season until the close of waterfowl season)

- All Fish
- Channel Catfish
- Large or Smallmouth Bass
- Large or Smallmouth Bass (14)
- Striped, White, or Hybrid
- Striped Bass (16)
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 18" Minimum Length Limit
- 3 Fish Daily Creel Limit
- 10 Creel/3 Fish 17" or Longer Daily (17)

Walleye, Sauger, or Hybrid

- Walleye
- Walleye, Sauger, or Hybrid
- Walleye (14)
- 22" Minimum Length Limit
- 3 Fish Daily Creel Limit

Hennepin Canal-Mainline & Feeder, Hennepin Canal Parkway State Park

- Multiple Counties
- All Fish
- Large or Smallmouth Bass
- 2 Pole and Line Fishing Only (1)(13)
- 14" Minimum Length Limit

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DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

Trout
Trout
Walleye, Sauger, or Hybrid
Walleye

- Fall Closed Season (10)
- Spring Closed Season (11)
- 14" Minimum Length Limit

Herrick Lake, DuPage County Forest Preserve District
DuPage County
All Fish
Channel Catfish

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Hidden Springs State Forest Ponds, Hidden Springs State Forest
Shelby County
All Fish
Channel Catfish
Large or Smallmouth Bass

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit

Highland Old City Lake, City of Highland
Madison County
All Fish
Channel Catfish
Trout

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- Fall Closed Season (10)

Hillsboro Old City Lake, City of Hillsboro
Montgomery County
All Fish
Channel Catfish
Large or Smallmouth Bass

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 12-15" Slot Length Limit (3)

Homer Lake, Champaign County Forest Preserve District
Champaign County
All Fish
Channel Catfish
Large or Smallmouth Bass

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit

Hornel Ponds, Donnelly State Fish and Wildlife Area
Bureau County
All Fish
Channel Catfish
Large or Smallmouth Bass

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit

Horseshoe Lake-Alexander Co., Horseshoe Lake Conservation Area
Alexander County
(Only trolling motors in refuge from October 1-March 1)
All Fish
Channel Catfish
Large or Smallmouth Bass

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit

Horseshoe Lake State Park

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DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

Madison County
(Unlawful to trespass upon designated waterfowl hunting areas during the 3 days prior to the waterfowl season)

- 2 Pole and Line Fishing Only (1)
- 15" Minimum Length Limit
- 3 Fish Daily Creel Limit
- 25 Fish Daily Creel Limit

White, Black or Hybrid Crappie (15)

Horton Lake, Nauvoo State Park
Hancock County
All Fish
Channel Catfish

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Humbolt Park Lagoon, Chicago Park District
Cook County
All Fish
Channel Catfish

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Ill. Dept. of Transportation-Lake, State of Illinois
Sangamon County
All Fish
Channel Catfish

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Illinois & Michigan Canal, State of Illinois
Grundy/LaSalle Counties
All Fish
Channel Catfish

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Illinois Beach State Park Ponds, Illinois Beach State Park
Lake County
All Fish
Channel Catfish

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Illinois Department of Transportation Lake, State of Illinois
Sangamon County
All Fish
Channel Catfish

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Jackson Park (Columbia Basin) Lagoon, Chicago Park District
Cook County
All Fish
Channel Catfish

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Johnson Sauk Trail Lake & Pond, Johnson Sauk Trail State Park
Henry County
All Fish
Channel Catfish
Large or Smallmouth Bass

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

Jones Park Lake, City of East St. Louis

St. Clair County
 All Fish
 Channel Catfish
 Trout
 Trout
 - 2 Pole and Line Fishing Only (1)
 - 6 Fish Daily Creel Limit
 - Fall Closed Season (10)
 - Spring Closed Season (11)

Jones State Lake, Saline County Conservation Area

Saline County
 All Fish
 Channel Catfish
 Large or Smallmouth Bass
 - 2 Pole and Line Fishing Only (1)
 - 6 Fish Daily Creel Limit
 - 14" Minimum Length Limit

Jones Lake Trout Pond, Saline County Conservation Area

Saline County
 Trout
 Trout
 - Fall Closed Season (10)
 - Spring Closed Season (11)

Jubilee College State Park Ponds, Jubilee College State Park

Peoria County
 All Fish
 Channel Catfish
 - 2 Pole and Line Fishing Only (1)
 - 6 Fish Daily Creel Limit

Kaskaskia River & all tributaries, State of Illinois

Multiple Counties
 Walleye, Sauger, or Hybrid
 Walleye
 - 14" Minimum Length Limit

Kaskaskia River Fish and Wildlife Area - Doza Creek Wildlife Management Area

St. Clair County
 (Closed to all public use 3 days prior to waterfowl hunting season)

Kendall Co. Lake #1, Kendall County Forest Preserve District

Kendall County
 All Fish
 Channel Catfish
 Large or Smallmouth Bass
 Large or Smallmouth Bass (14)
 - 2 Pole and Line Fishing Only (1)
 - 6 Fish Daily Creel Limit
 - 14" Minimum Length Limit
 - 3 Fish Daily Creel Limit

Kent Creek, State of Illinois

Winnebago County
 Trout
 - Spring Closed Season (11)

Kickapoo State Park Lakes & Ponds, Kickapoo State Park

Vermillion County
 All Fish
 Channel Catfish
 - 2 Pole and Line Fishing Only (1)
 - 6 Fish Daily Creel Limit

Kinkaid Lake, Kinkaid Lake State Fish and Wildlife Area

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

Jackson County

Large or Smallmouth Bass
 Pure Muskellunge
 Walleye, Sauger, or Hybrid
 Walleye
 - 18" Minimum Length Limit
 - 36" Minimum Length Limit
 - 14" Minimum Length Limit

Lake Atwood, McHenry County Conservation District

McHenry County
 All Fish
 Channel Catfish
 Trout
 - 2 Pole and Line Fishing Only (1)
 - 6 Fish Daily Creel Limit
 - Spring Closed Season (11)

Lake Bloomington, City of Bloomington

McLean County
 Large or Smallmouth Bass
 Striped, White, or Hybrid
 Striped Bass
 Striped, White, or Hybrid
 Striped Bass (16)
 Walleye, Sauger, or Hybrid
 Walleye
 - 15" Minimum Length Limit
 - 17" Minimum Length Limit
 - 3 Fish Daily Creel Limit
 - 14" Minimum Length Limit

Lake Carlton, Morrison-Rockwood State Park

Whiteside County
 All Fish
 Channel Catfish
 Large or Smallmouth Bass (14)
 Large or Smallmouth Bass
 Pure Muskellunge
 Walleye, Sauger, or Hybrid
 Walleye
 White, Black, or Hybrid
 Crappie (15)
 - 2 Pole and Line Fishing Only (1)
 - 6 Fish Daily Creel Limit
 - 1 Fish Daily Creel Limit
 - 14" Minimum Length Limit
 - 36" Minimum Length Limit
 - 14" Minimum Length Limit
 - 25 Fish Daily Creel Limit

Lake Co. Forest Preserve District Lakes, Lake County Forest Preserve District

Lake County
 All Fish
 Channel Catfish
 Large Smallmouth Bass (14)
 Large or Smallmouth Bass
 - 2 Pole and Line Fishing Only (1)
 - 6 Fish Daily Creel Limit
 - 1 Fish Daily Creel Limit
 - 15" Minimum Length Limit

Lake Decatur, City of Decatur

Macon County
 All Fish
 Large or Smallmouth Bass
 Walleye, Sauger, or Hybrid
 Walleye
 - 2 Pole and Line Fishing Only (1)
 - 14" Minimum Length Limit
 - 14" Minimum Length Limit

Lake Depue Fish and Wildlife Area

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

Bureau County
(Unlawful to trespass upon designated waterfowl hunting areas 7 days prior to the waterfowl season, and on areas designated as waterfowl refuges from October 10 until the end of the waterfowl season)

Lake Eureka, City of Eureka
Woodford County

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 15" Minimum Length Limit
- 2 Fish - 15" - 4" or 1 Fish - 15" - 15" Bass (14)
- 1 Fish Daily Creel Limit

Lake George, Loud Thunder Forest Preserve
Rock Island County

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit
- 36" Minimum Length Limit
- 14" Minimum Length Limit
- 25 Fish Daily Creel Limit

Lake Stender, Shawnee-National Forest
Pope County

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Lake Jacksonville, City of Jacksonville
Morgan County

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 15" Minimum Length Limit
- 17" Minimum Length Limit
- 3 Fish Daily Creel Limit
- 25 Fish Daily Creel Limit
- 9" Minimum Length Limit

Lake Kakusha, City of Mendota
LaSalle County

- 2 Pole and Line Fishing Only (1)
- 10 Fish Daily Creel Limit
- 6 Fish Daily Creel Limit

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

- 14" Minimum Length Limit
- 3 Fish Daily Creel Limit
- 10 Fish Daily Creel Limit

Lake Le-Aqua-Na, Lake Le-Aqua-Na State Park
Stephenson County

- 2 Pole and Line Fishing Only (1)
- 10 Fish Daily Creel Limit
- 6 Fish Daily Creel Limit
- 1 Fish Daily Creel Limit
- 14" Minimum Length Limit
- 14" Minimum Length Limit
- 25 Fish Daily Creel Limit

Lake Mendota, City of Mendota
LaSalle County

- 6 Fish Daily Creel Limit
- 1 Fish Daily Creel Limit
- 15" Minimum Length Limit

Lake Michigan (Illinois Portion), State of Illinois
Lake/Cook Counties

- 10" Minimum Length Limit
- no more than 3 fish of any one species daily, except for Lake Trout
- 2 Fish Daily Creel Limit

Lake Milliken, Des Plaines Conservation Area
Will County

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 15" Minimum Length Limit
- Spring Closed Season (1)

Lake Mingo & Ponds, Vermilion County Conservation Area
Vermilion County

- 2 Pole and Line Fishing Only (1)
- 25 Fish Daily Creel Limit
- 6 Fish Daily Creel Limit
- 15" Minimum Length Limit
- 13" Minimum Length Limit

Lake Murphysboro, Lake Murphysboro State Park

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

Jackson County

- All Fish
- Bluegill or Redear Sunfish (14)
- Channel Catfish
- Large or Smallmouth Bass
- 2 Pole and Line Fishing Only (1)
- 25 Fish Daily Creel Limit
- 6 Fish Daily Creel Limit
- 15" Minimum Length Limit

Lake Nellie, City of Effingham

- Fayette County
- All Fish
- Channel Catfish
- Large or Smallmouth Bass
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit

Lake of the Woods & Elk's Pond, Champaign County Forest Preserve District
Champaign County

- All Fish
- Channel Catfish
- Large or Smallmouth Bass
- Large or Smallmouth Bass (14)
- Trout
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 15" Minimum Length Limit
- 1 Fish Daily Creel Limit
- Spring Closed Season (11)

Lake Olson, Rock Cut State Park

- Winnebago County
- All Fish
- Channel Catfish
- Large or Smallmouth Bass
- Large or Smallmouth Bass (14)
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit
- 1 Fish Daily Creel Limit

Lake Paradise & Shadow Ponds, City of Mattoon

- Coles County
- All Fish
- Large or Smallmouth Bass
- 2 Pole and Line Fishing Only (1)
- 14" Minimum Length Limit

Lake Paradise Shadow Ponds, City of Mattoon

- Coles County
- All Fish
- Large or Smallmouth Bass
- Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 14" Minimum Length Limit
- 6 Fish Daily Creel Limit

Lake Sara, City of Effingham

- Effingham County
- Large or Smallmouth Bass
- Walleye, Sauger, or Hybrid
- Walleye
- White, Black, or Hybrid
- Crappie (15)
- 14" Minimum Length Limit
- 14" Minimum Length Limit
- 25 Fish Daily Creel Limit

Lake Shelbyville (21), U.S. Army Corps of Engineers

- Moultrie/Shelby Counties
- Large or Smallmouth Bass
- 14" Minimum Length Limit

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

- Pure Muskellunge
- Walleye, Sauger, or Hybrid
- Walleye
- White, Black, or Hybrid
- Crappie (15)
- White, Black, or Hybrid
- Crappie
- 36" Minimum Length Limit
- 14" Minimum Length Limit
- 10 Fish Daily Creel Limit
- 10" Minimum Length Limit

Lake Shelbyville Ponds & Woods Lake, Lake Shelbyville State Fish and Wildlife Area

- Moultrie/Shelby Counties
- All Fish
- Channel Catfish
- Large or Smallmouth Bass
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit

Lake Springfield, City of Springfield

- Sangamon County
- All Fish
- Large or Smallmouth Bass
- Walleye, Sauger, or Hybrid
- Walleye
- White, Black, or Hybrid
- Crappie (15)
- White, Black, or Hybrid
- Crappie
- 2 Pole and Line Fishing Only (1)
- 15" Minimum Length Limit
- 14" Minimum Length Limit
- 25 Fish Daily Creel Limit
- 9" Minimum Length Limit

Lake Storey, City of Galesburg

- Knox County
- All Fish
- Bluegill or Redear Sunfish (14)
- Channel Catfish
- Large or Smallmouth Bass
- Walleye, Sauger, or Hybrid
- Walleye
- Walleye, Sauger, or Hybrid
- Walleye (14)
- 2 Pole and Line Fishing Only (1)
- 25 Fish Daily Creel Limit
- 6 Fish Daily Creel Limit
- 12-15" Slot Length Limit (3)
- 14" Minimum Length Limit
- 3 Fish Daily Creel Limit

Lake Sule, Flagg-Rochelle Park District

- Ogle County
- All Fish
- Channel Catfish
- Large or Smallmouth Bass
- Large or Smallmouth Bass (14)
- Pure Muskellunge
- Walleye, Sauger, or Hybrid
- Walleye
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit
- 1 Fish Daily Creel Limit
- 36" Minimum Length Limit
- 14" Minimum Length Limit

Lake Taylorville, City of Taylorville

Christian County

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

- Large or Smallmouth Bass
White, Black, or Hybrid
Crappie
White, Black, or Hybrid
Crappie (15)
- 15" Minimum Length Limit
- 9" Minimum Length Limit
- 25 Fish Daily Creel Limit
- Lake Vandalia, City of Vandalia
Fayette County
- All Fish
Channel Catfish
Large or Smallmouth Bass
Striped, White, or Hybrid
Striped Bass
Striped, White, or Hybrid
Striped Bass (16)
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit
- 17" Minimum Length Limit
- 3 Fish Daily Creel Limit
- Lake Vermilion, Vermilion County Conservation District
Vermilion County
- All Fish
Large or Smallmouth Bass
Pure Muskellunge
Walleye, Sauger, or Hybrid
Walleye
- 2 Pole and Line Fishing Only (26)
- 15" Minimum Length Limit (23)
- 36" Minimum Length Limit (23)
- 14" Minimum Length Limit (23)
- Lake Williamsville, City of Williamsville
Sangamon County
- All Fish
Channel Catfish
Large or Smallmouth Bass
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 15" Minimum Length Limit
- LaSalle Lake, LaSalle Power Station
LaSalle County
- All Fish
Large or Smallmouth Bass (14)
Large or Smallmouth Bass
Striped, White, or Hybrid
Striped Bass (16)
- 2 Pole and Line Fishing Only (1)
- 1 Fish Daily Creel Limit
- 18" Minimum Length Limit
- 10 Creel/3 Fish 17" or Longer Daily (17)
- Lincoln Log Cabin Pond, Lincoln Log Cabin Historical Site
Coles County
- All Fish
- 2 Pole and Line Fishing Only (1)
- Lincoln Park North Lagoon, Chicago Park District
Cook County
- All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- Lincoln Park South Lagoon, Chicago Park District

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

- Cook County
- All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- Lincoln Trail Lake, Lincoln Trail State Park
Clark County
- All Fish
Channel Catfish
Large or Smallmouth Bass
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 12-15" Slot Length Limit (3)
- Little Black Slough, Little Black Slough State Natural Area
Johnson County
- All Fish
All Fish
- 2 Pole and Line Fishing Only (1)
- No Seines
- Little Cedar-Baker-Shawnee-National Forest
Jackson County
- All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- Little Sister Lake, County of Fulton
Fulton County
- All Fish
Bluegill or Redear Sunfish (14)
Channel Catfish
Large or Smallmouth Bass
Large or Smallmouth Bass (14)
- 2 Pole and Line Fishing Only (1)
- 10 Fish Daily Creel Limit
- 6 Fish Daily Creel Limit
- 15" Minimum Length Limit
- 3 Fish Daily Creel Limit
- Lou Yeager Lake, City of Litchfield
Montgomery County
- Large or Smallmouth Bass
Large or Smallmouth Bass (14)
- 15" Minimum Length Limit
- 3 Fish Daily Creel Limit
- Lower Cache River, Lower Cache River State Natural Area
Pulaski/Johnson Counties
- All Fish
All Fish
- 2 Pole and Line Fishing Only (1)
- No Seines
- Lyerla Lake, Union County Conservation Area
Union County
- All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- Macon County Conservation District Ponds, Macon County Conservation District
Macon County
- All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- Maple Lake, Cook County Forest Preserve District

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

Cook County
All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Marquette Park Lagoon, Chicago Park District
Cook County
All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Marshall County Conservation Area (Fishing Ditch), Marshall County
Marshall County
(Unlawful to trespass upon designated waterfowl hunting areas 7 days prior to the waterfowl season and on areas designated as waterfowl refuges from October 10 until the end of the waterfowl season)
All Fish
- 2 Pole and Line Fishing Only (1)

Mattoon Lake, City of Mattoon
Coles County
All Fish
Large or Smallmouth Bass
- 2 Pole and Line Fishing Only (1)
- 14" Minimum Length Limit

Mazonia-Braidwood Lakes & Ponds, Mazonia-Braidwood State Fish and Wildlife Area
Grundy/Will Counties
(Unlawful to fish or trespass upon the designated waterfowl hunting areas or refuge beginning 2 weeks prior to the waterfowl season until the end of the waterfowl season at Mazonia Fish and Wildlife Area. Braidwood Lake is closed to all fishing and boat traffic from 2 weeks prior to duck season through the day before duck season and is closed to all fishing during waterfowl season commencing with duck season)
All Fish
Channel Catfish
Large or Smallmouth Bass
Large or Smallmouth Bass (14)
Striped, White, or Hybrid
Striped Bass
Striped, White, or Hybrid
Striped Bass (16)
Walleye, Sauger, or Hybrid
Walleye
White, Black or Hybrid
Crappie (15)
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 15" Minimum Length Limit
- 3 Fish Daily Creel Limit
- 17" Minimum Length Limit
- 3 Fish Daily Creel Limit
- 14" Minimum Length Limit
- 10 Fish Daily Creel Limit

Mautino Fish and Wildlife Area, Mautino Fish and Wildlife Area
Bureau County
All Fish
Bluegill or Redear Sunfish (14)
Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 10 Fish Daily Creel Limit
- 6 Fish Daily Creel Limit

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

Large or Smallmouth Bass
Large or Smallmouth Bass (14)
- 14" Minimum Length Limit
- 1 Fish Daily Creel Limit

McCullom Lake, City of McHenry
McHenry County
All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

McKinley Park Lagoon, Chicago Park District
Cook County
All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

McLeansboro City Lakes, City of McLeansboro
Hamilton County
All Fish
Channel Catfish
Large or Smallmouth Bass
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
14" Minimum Length Limit

Meredosia Lake - Cass County Portion
Cass County
(Meandered waters only) (All boat traffic is prohibited from operating on meandered waters (except non-motorized boats may be used to assist in the retrieval of waterfowl shot from private land) from the period from one week before waterfowl season opens until the season closes; hunting and/or any other activity is prohibited during the period from one week before waterfowl season opens until the season closes)
Mernett State Lake, Mernett Lake Conservation Area
Massac County
(All boats prohibited from entering the duly posted waterfowl refuge (Main Lake) from October 1 until the close of the waterfowl season)
All Fish
Channel Catfish
Large or Smallmouth Bass
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit

Middle Fork Forest Preserve Ponds, Champaign County Forest Preserve
Champaign County
All Fish
Bluegill or Redear Sunfish (14)
Channel Catfish
Large or Smallmouth Bass
- 2 Pole and Line Fishing Only (1)
- 25 Fish Daily Creel Limit
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit

Mill Creek Lake, Clark County Park District
Clark County
All Fish
Channel Catfish
Large or Smallmouth Bass
Walleye, Sauger, or Hybrid
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 12-15" Slot Length Limit (3)

ILLINOIS REGISTER
DEPARTMENT OF CONSERVATION
NOTICE OF ADOPTED AMENDMENT(S)

- Walleye - 14" Minimum Length Limit
- Miller Park Lake, City of Bloomington
McLean County
All Fish
Channel Catfish
Trout
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- Spring Closed Season (11)
- Mineral Springs Park Lagoon, City of Pekin
Tazewell County
All Fish
Channel Catfish
Trout
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- Fall Closed Season (10)
- Mississippi River (between IL & IA), State of Illinois
Multiple Counties
Large or Smallmouth Bass
Northern Pike
Walleye and Sauger (14)
Walleye
- 14" Minimum Length Limit
- 5 Fish Daily Creel Limit
- 10 Fish Daily Creel Limit (24)
- 15" Minimum Length Limit
- Mississippi River (between IL & MO), State of Illinois
Multiple Counties
(Boating prohibited on refuge area immediately south of Melvin Price Lock and Dam 26 from October 15-April 15)
Northern Pike
Walleye and Sauger (14)
- 1 Fish Daily Creel Limit
- 8 Fish Daily Creel Limit
- Monroe Reservoir, Will County Forest Preserve District
Will County
All Fish
Channel Catfish
Large or Smallmouth Bass (14)
Large or Smallmouth Bass
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 1 Fish Daily Creel Limit
- 15" Minimum Length Limit
- Montrose Lake, City of Montrose
Cumberland County
All Fish
Channel Catfish
Large or Smallmouth Bass
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit
- Mt. Olive City Lakes, City of Mt. Olive
Macoupin County
All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- Mt. Sterling Lake, City of Mt. Sterling
Brown County
Channel Catfish
- 6 Fish Daily Creel Limit

ILLINOIS REGISTER
DEPARTMENT OF CONSERVATION
NOTICE OF ADOPTED AMENDMENT(S)

- Large or Smallmouth Bass - 12-15" Slot Length Limit (3)
- Mt. Vernon Game Farm Pond, Mt. Vernon Game Farm
Jefferson County
Trout
Trout
- Fall Closed Season (10)
- Spring Closed Season (11)
- Mundelein Park Dist. (Diamond Lake & Park Ponds), City of Mundelein
Lake County
All Fish
Channel Catfish
Large or Smallmouth Bass
Large or Smallmouth Bass (14)
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 15" Minimum Length Limit
- 3 Fish Daily Creel Limit
- Nashville City Lake, City of Nashville
Washington County
All Fish
Channel Catfish
Large or Smallmouth Bass
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 18" Minimum Length Limit
- Newton Lake, Newton Lake State Fish and Wildlife Area
Jasper County
All Fish
Large or Smallmouth Bass
Large or Smallmouth Bass (14)
Walleye, Sauger, or Hybrid
Walleye
White, Black, or Hybrid
Crappie (15)
White, Black, or Hybrid
Crappie
- 2 Pole and Line Fishing Only (1)
- 18" Minimum Length Limit
- 3 Fish Daily Creel Limit
- 14" Minimum Length Limit
- 10 Fish Daily Creel Limit
- 10" Minimum Length Limit
- Oakland City Lake, City of Oakland
Coles County
All Fish
Channel Catfish
Large or Smallmouth Bass
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit
- Ohio River (between Illinois & Kentucky), State of Illinois
Multiple Counties
Large or Smallmouth Bass
Northern Pike
Muskie or Tiger Muskie
Walleye, Sauger, or Hybrid
Walleye (14)
White, Black, or Hybrid
Crappie (15)
Striped, White, Yellow or Hybrid
Striped Bass
- 12" Minimum Length Limit
- No Length or Creel Limit
- 2 Fish Daily Creel Limit
- 10 Fish Daily Creel Limit
- 30 Fish Daily Creel Limit
- 30 Creel, 4 Fish 15" or longer

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

Daily (32)

One-Horse-Gap-Baker-Shawnee-National-ForestGallatin-CountyAll-FishChannel-Catfish

Otter Lake, Otter Lake Water Commission
Macoupin County

- Large or Smallmouth Bass
- Striped, White, or Hybrid
- Striped Bass
- Striped, White, or Hybrid
- Striped Bass (16)
- Pure Muskellunge
- 15" Minimum Length Limit
- 17" Minimum Length Limit
- 3 Fish Daily Creel Limit
- 36" Minimum Length Limit

Palmyra City Lake & Terry Park Pond, City of Palmyra

Macoupin CountyAll FishChannel Catfish

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Pana Lake, City of Pana

Shelby and Christian Counties

All FishChannel CatfishLarge or Smallmouth Bass

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit

Paris East & West Lakes, City of Paris

Edgar CountyAll FishChannel CatfishLarge or Smallmouth Bass

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit

Peelman Lake, Kickapoo State Park

Vermilion CountyLarge or Smallmouth Bass

- 14" Minimum Length Limit

Pierce Lake, Rock Cut State Park

Winnebago CountyAll FishBluegill or Redear Sunfish (14)Channel CatfishLarge or Smallmouth Bass (14)Large or Smallmouth BassPure MuskellungeWalleye, Sauger, or HybridWalleyeWhite, Black, or HybridCrappie (15)

- 2 Pole and Line Fishing Only (1)(8)
- 5 Fish Daily Creel Limit
- 6 Fish Daily Creel Limit
- 1 Fish Daily Creel Limit
- 14" Minimum Length Limit
- 36" Minimum Length Limit
- 14" Minimum Length Limit
- 25 Fish Daily Creel Limit

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

Pickneyville Lake, City of Pickneyville

Perry CountyLarge or Smallmouth BassLarge or Smallmouth Bass (14)

- 18" Minimum Length Limit
- 1 Fish Daily Creel Limit

Pine Creek, State of Illinois

Ogle CountyTrout

- Spring Closed Season (11)

Piscasaw Creek, State of Illinois

McHenry CountyTroutTrout

- 9" Minimum Length Limit
- Spring Closed Season (11)

Pittsfield City Lake, City of Pittsfield

Pike CountyLarge or Smallmouth BassStriped, White, or HybridStriped BassStriped, White, or HybridStriped Bass (16)Walleye, Sauger, or HybridWalleye

- 14" Minimum Length Limit
- 17" Minimum Length Limit
- 3 Fish Daily Creel Limit
- 14" Minimum Length Limit

Pocahontas Park Pond, City of Pocahontas

Bond CountyAll FishChannel Catfish

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Pounds-Hollow-Baker-Shawnee-National-Forest

Gallatin-CountyAll-FishChannel-Catfish

- 2-Pole-and-Line-Fishing-Only (1)
- 6-Fish-Daily-Creel-Limit

Powerton Lake, Powerton Lake Fish and Wildlife Area

Tazewell County

(Closed to boat traffic from October 1-February 15, except for legal waterfowl hunters; closed to all unauthorized entry during the waterfowl season)

All FishChannel CatfishLarge or Smallmouth BassLarge or Smallmouth Bass (14)Striped, White, or HybridStriped Bass (16)

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 18" Minimum Length Limit
- 3 Fish Daily Creel Limit
- 10 Creel/3 Fish 17" or longer Daily (17)

Walleye, Sauger, or HybridWalleye (14)Walleye, Sauger, or HybridWalleye

- 1 Fish Daily Creel Limit
- 24" Minimum Length Limit

DEPARTMENT OF CONSERVATION

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

NOTICE OF ADOPTED AMENDMENT' (S)

Pratt Wayne Woods Lakes, DuPage County Forest Preserve

- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Prospect Pond, City of Moline

Island County
Trout - Fall Closed Season (10)

Pyramid State Park Lakes & Ponds, Pyramid State Park

County
All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
--6 Fish Daily Creel Limit

Ramsey Lake, Ramsey Lake State Park

-	2 Pole and Line Fishing Only (1)
-	25 Fish Daily Creel Limit
-	6 Fish Daily Creel Limit
-	14" Minimum Length Limit
-	14" Minimum Length Limit
-	10 Fish Daily Creel Limit
-	9" Minimum Length Limit

Randolph County Lake, Randolph County Conservation Area

Species	2 Pole and Line Fishing Only (1)
Ph County	
All Fish	- 6 Fish Daily Creel Limit
Channel Catfish	- 14" Minimum Length Limit
Large or Smallmouth Bass	- 3 Fish Daily Creel Limit
Large or Smallmouth Bass (14)	- Fall Closed Season (10)
Trout	- 14" Minimum Length Limit
Walleye, Sauger, or Hybrid Walleye	

Red Hills Lake, Red Hills State Park

Species	2 Pole and Line Fishing Only (1)
Channel Catfish	6 Fish Daily Creel Limit
Large or Smallmouth Bass	15" Minimum Length Limit

Red's Landing Wildlife Management Area

Calhoun County
(Walk-in area closed to trespassing 3 days prior to duck season)

Rend Lake, (22) U.S. Army Corps of Engineers
Franklin County

(All boat traffic is prohibited from entering the duly posted waterfowl refuge and the subinboundments from 2 weeks before waterfowl season until March 1 except that boats used by waterfowl hunters are permitted in the subinboundments from 4:30 a.m. until 2 p.m. during the waterfowl season, except during the last 3 days of the Canada goose season, boats used by waterfowl hunters are permitted in the subinboundments from 4:30 a.m. until one hour after sunset. The land portion of the Rend Lake Refuge is closed to trespassing during waterfowl season)

Large or Smallmouth Bass
Striped, White, Yellow, or Hybrid
Striped Bass (16 33)
- 14" Minimum Length Limit
- 10 Creel/3 Fish 17" or longer Daily
(17)

SECRET
ATTENTION - SECURITY -
SECRET

Rend Lake Project Ponds Pond, U.S. Army Corps of Engineers

- 2 Pole and Line Fishing Only (11)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit
- 3 Fish Daily Creel Limit

Ridge Lake, Fox Ridge State Park

Species	Minimum Length Limit	Minimum Length Limit
2 Pole and Line Fishing Only (1)	- 14"	- 14"
All Fish	- 14"	- 14"
Channel Catfish	- 14"	- 14"
Large or Smallmouth Bass	- 14"	- 14"
Walleye, Sauger, or Hybrid Walleye	- 14"	- 14"

Riis Park Lagoon, Chicago Park District

County
All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
6 Fish Daily Creel Limit

Rock Creek, State of Illinois

Lee County
Trout
- Spring Closed Season (11)

Rock River Main Stem Only, State of Illinois

Large or Smallmouth Bass	- 12" Minimum Length Limit
Walleye, Sauger, and Hybrid Walleye	- 14" Minimum Length Limit

Rock River Main Stem Only (from Oregon Dam to State Route 2 Highway Bridge at Grand Detour), State of Illinois

- Catch and Release Fishing Only (9)

DEPARTMENT OF CONSERVATION

NOTICE OF ADOPTED AMENDMENT(S)

Rock Springs Pond, Macon County Conservation District
Macon County

Trout
- Spring Closed Season (11)

Roodhouse Park Lake, City of Roodhouse
Green County

All Fish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Channel Catfish

St. Elmo South Lake, City of St. Elmo

Fayette County
All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Sam Dale Conservation Area Lake & Pond, Sam Dale Conservation Area

Wayne County
All Fish
Channel Catfish
Large or Smallmouth Bass
Walleye, Sauger
and Hybrid Walleye
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit
- 14" Minimum Length Limit

Sam Dale Trout Pond, Sam Dale Conservation Area

Wayne County
All Fish
Channel Catfish
Large or Smallmouth Bass
Trout
Trout
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit
- Fall Closed Season (10)
- Spring Closed Season (11)

Sam Parr Lake, Sam Parr State Park

Jasper County
All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Sand Lake, Illinois Beach State Park

Lake County
Channel Catfish
Large or Smallmouth Bass
Large or Smallmouth Bass (14)
Trout
- 6 Fish Daily Creel Limit
- 15" Minimum Length Limit
- 1 Fish Daily Creel Limit
- Fall Closed Season (10)

Sangamon Conservation Area

Mason, Cass, Schuyler, and Menard Counties
(Unlawful to trespass upon designated waterfowl hunting areas during the 3
days prior to the waterfowl season; fishing prohibited in impoundment areas
during the waterfowl season; no trespassing at Barkhausen Refuge October 1
through end of goose season; no person shall trespass on the Marion Pickrel
Refuge October 1 through the last day of waterfowl season unless proper

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permission is granted by the site superintendent)

Sangchris Lake, Sangchris Lake State Park

Christian/Sangamon Counties
(Posted waterfowl refuge closed to all boat traffic during waterfowl season;
Bank fishing along the dam shall be permitted. Fishing shall be prohibited in
the east and west arms of the lake during the period from 10 days prior to the
duck season through the end of the duck season. Fishing shall be prohibited
in the west arm of the lake and the east arm of the lake south of the power
lines during that portion of the goose season that follows the duck season)

All Fish
Large or Smallmouth Bass (14)
- 2 Pole and Line Fishing Only (1)
- 2 Fish <15" &/or 1 Fish >or
=15 " Daily (25)

White, Black, or Hybrid

Crappie (15)
- 25 Fish Daily Creel Limit

White, Black, or Hybrid

Crappie
- 9" Minimum Length Limit

Sangchris Lake Park Ponds, Sangchris Lake State Park

Sangamon County
All Fish
- 2 Pole and Line Fishing Only (1)

Schuy-Rush Lake, City of Rushville

Schuyler County
Walleye, Sauger, or Hybrid
Walleye
- 14" Minimum Length Limit
White, Black, or Hybrid
Crappie
- 9" Minimum Length Limit

Senior Citizen's Pond, Kankakee River State Park

Kankakee County
All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

Shabbona Lake, Shabbona Lake State Park

DeKalb County
All Fish
Bluegill or Redear Sunfish (14)
Channel Catfish
Large or Smallmouth Bass (14)
Large or Smallmouth Bass
Pure Muskellunge
Walleye, Sauger, or Hybrid
Walleye
White, Black, or Hybrid
Crappie (15)
- 2 Pole and Line Fishing Only (1)
- 10 Fish Daily Creel Limit
- 6 Fish Daily Creel Limit
- 1 Fish Daily Creel Limit
- 14" Minimum Length Limit
- 36" Minimum Length Limit
- 14" Minimum Length Limit
- 10 Fish Daily Creel Limit

Shawnee National Forest Lakes & Ponds, Shawnee National Forest U.S. Forest
Service

Front Lake School Library

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- Multiple Counties
All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- Shawnee National Forest - Ponds less than 10 acres, U.S. Forest Service
Multiple Counties
Largemouth Bass
- 12" Minimum Length Limit
- Shawnee National Forest - Bay Creek Lake, U.S. Forest Service
Pope County
All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- Shawnee National Forest - Dutchman Lake, U.S. Forest Service
Johnson County
All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- Shawnee National Forest - Lake Glendale, U.S. Forest Service
Pope County
All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- Shawnee National Forest - Little Cedar Lake, U.S. Forest Service
Jackson County
All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- Shawnee National Forest - One Horse Gap Lake, U.S. Forest Service
Gallatin County
All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- Shawnee National Forest - Pounds Hollow Lake, U.S. Forest Service
Gallatin County
All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- Shawnee National Forest - Tecumseh Lake, U.S. Forest Service
Hardin County
All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- Shawnee National Forest - Whoopee Cat Lake, U.S. Forest Service
Hardin County
All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- Sherman Park Lagoon, Chicago Park District
All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit

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NOTICE OF ADOPTED AMENDMENT(S)

- Cook County
All Fish
Channel Catfish
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- Siloam Springs Lake, Siloam Springs State Park
Adams County
All Fish
Channel Catfish
Large or Smallmouth Bass
Trout
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 12-15" Slot Length Limit (3)
- Fall Closed Season (10)
- Spring Closed Season (11)
- Silver Lake, DuPage County Forest Preserve District
DuPage County
Trout
- Spring Closed Season (11)
- Silver Lake (Highland), City of Highland
Madison County
Walleye, Sauger, or Hybrid
Walleye
- 14" Minimum Length Limit
- Silver Springs S.P. Lake (Big Lake) & Ponds, Silver Springs State Park
Kendall County
All Fish
Channel Catfish
Large or Smallmouth Bass
Trout
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 15" Minimum Length Limit
- Fall Closed Season (10)
- Spring Closed Season (11)
- Snake Den Hollow Lakes, Snake Den Hollow State Fish and Wildlife Area
Knox County
All use other than waterfowl hunting prohibited from October 1 through the end of the goose season
All Fish
Bluegill or Redear Sunfish (14)
Channel Catfish
Large or Smallmouth Bass
Large or Smallmouth Bass (14)
Pure Muskellunge
Walleye, Sauger, or Hybrid
Walleye (14)
Walleye, Sauger, or Hybrid
Walleye
White, Black, or Hybrid
Crappie (15)
- 2 Pole and Line Fishing Only (1)
- 5 10 Fish Daily Creel Limit
- 6 Fish Daily Creel Limit
- 15" Minimum Length Limit
- 3 Fish Daily Creel Limit
- 36" Minimum Length Limit
- 3 Fish Daily Creel Limit
14" Minimum Length Limit
- 5 Fish Daily Creel Limit
- Sparta City Lakes, City of Sparta
Randolph County
All Fish
- 2 Pole and Line Fishing Only (1)

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Channel Catfish
Large or Smallmouth Bass

Spring Lake, City of Macomb
McDonough County

- All Fish
- Channel Catfish
- Large or Smallmouth Bass
- Large or Smallmouth Bass (14)
- Striped, White, or Hybrid
- Striped Bass
- Striped, White, or Hybrid
- Striped Bass (16)
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 15" Minimum Length Limit
- 3 Fish Daily Creel Limit
- 17" Minimum Length Limit
- 3 Fish Daily Creel Limit

Spring Lake (North & South), Spring Lake Conservation Area

Tazewell County
(Unlawful to trespass upon designated waterfowl hunting areas 7 days prior to the waterfowl season and on areas designated as waterfowl refuges from October 10 until the end of the waterfowl season)

- All Fish
- Channel Catfish
- Large or Smallmouth Bass
- Pure Muskellunge
- White, Black, or Hybrid
- Crappie (15)
- White, Black, or Hybrid
- Crappie
- 2 Pole and Line Fishing Only (1)(7)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit
- 36" Minimum Length Limit
- 25 Fish Daily Creel Limit
- 9" Minimum Length Limit

St. Bimo-South-baker-City-of-St.-Bimo

Payette-County

All-Fish

Channel-Catfish

Staunton City Lake, City of Staunton

Macoupin County

- All Fish
- Channel Catfish
- Large or Smallmouth Bass
- Large or Smallmouth Bass (14)
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 15" Minimum Length Limit
- 3 Fish Daily Creel Limit

Sterling Lake, Lake County Forest Preserve District

Lake County

- All Fish
- Channel Catfish
- Large or Smallmouth Bass (14)
- Large or Smallmouth Bass
- Pure Muskellunge
- Walleye, Sauger, or Hybrid
- Walleye
- 2 Pole & Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 1 Fish Daily Creel Limit
- 15" Minimum Length Limit
- 36" Minimum Length Limit
- 14" Minimum Length Limit

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Stump Lake Wildlife Management Area

Jersey County

(Unlawful to trespass upon designated waterfowl hunting areas during the 3 days prior to the waterfowl season)

Tampier Lake, Cook County Forest Preserve

Cook County

- All Fish
- Channel Catfish
- Walleye, Sauger, or Hybrid
- Walleye
- 2 Pole and Line Fishing Only
- 6 Fish Daily Creel Limit
- 16" Minimum Length Limit

Peconish-lake-Shawnee-National-Forest

Hardin-County

All-Fish

Channel-Catfish

--2-Pole-and-line-Fishing-Only-(1)

--6-Fish-Daily-Creel-Limit

Ten Mile Creek Lakes, Ten Mile Creek State Fish and Wildlife Area

Hamilton/Jefferson Counties

(Areas designated as refuge are closed to all access during the Canada goose season)

- All Fish
- Channel Catfish
- Large or Smallmouth Bass
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit

Tomahawk Lake, Moraine Hills State Park

McHenry County

- All Fish
- Channel Catfish
- Large or Smallmouth Bass
- Large or Smallmouth Bass (14)
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit
- 3 Fish Daily Creel Limit

Tremont Ponds, Village of Tremont

Tazewell County

- All Fish
- Channel Catfish
- Large or Smallmouth Bass
- Large or Smallmouth Bass (14)
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 15" Minimum Length Limit
- 1 Fish Daily Creel Limit

Turner Lake, Chain O'Lakes State Park

Lake County

- All Fish
- Channel Catfish
- Large or Smallmouth Bass (14)
- Large or Smallmouth Bass
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 1 Fish Daily Creel Limit
- 15" Minimum Length Limit

Tuscola City Lake, City of Tuscola

Douglas County

- All Fish
- 2 Pole and Line Fishing Only (1)

DEPARTMENT OF CONSERVATION

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Channel Catfish - 6 Fish Daily Creel Limit
 Large or Smallmouth Bass - 14" Minimum Length Limit

Union County Conservation AreaUnion County

(All fishing and boat traffic prohibited October 15-March 1)

Valley Lake, Wildwood Park District
Lake County

- 2 Pole and Line Fishing Only (1)
 Channel Catfish - 6 Fish Daily Creel Limit
 Large or Smallmouth Bass - 15" Minimum Length Limit
 Large or Smallmouth Bass (14) - 3 Fish Daily Creel Limit

Vandalia Correctional Facility Pond, State of IllinoisFayette County

- 2 Pole and Line Fishing Only (1)
 All Fish - 6 Fish Daily Creel Limit
 Channel Catfish

Vanhorn Woods Pond, Plainfield Park DistrictWill County

- 2 Pole and Line Fishing Only (1)
 All Fish - 6 Fish Daily Creel Limit
 Channel Catfish - 15" Minimum Length Limit
 Large or Smallmouth Bass (14) - 1 Fish Daily Creel Limit

Vernor Lake, City of OlneyRichland County

- 2 Pole and Line Fishing Only (1)
 All Fish - 6 Fish Daily Creel Limit
 Channel Catfish - 14" Minimum Length Limit
 Large or Smallmouth Bass

Villa Grove East Lake, City of Villa GroveDouglas County

- 2 Pole and Line Fishing Only (1)
 All Fish - 6 Fish Daily Creel Limit
 Channel Catfish - 14" Minimum Length Limit
 Large or Smallmouth Bass

Villa Grove West Lake, City of Villa GroveDouglas County

- 2 Pole and Line Fishing Only (1)
 All Fish - 6 Fish Daily Creel Limit
 Channel Catfish - 14" Minimum Length Limit
 Large or Smallmouth Bass - Fall Closed Season (10)
 Trout

Virginia City Reservoir, City of VirginiaCass County

- 2 Pole and Line Fishing Only (1)
 All Fish

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Channel Catfish - 6 Fish Daily Creel Limit
 Large or Smallmouth Bass - 15" Minimum Length Limit

Waddams Creek, State of IllinoisStephenson County

Trout - Spring Closed Season (11)

Walnut Point Lake, Walnut Point State Fish and Wildlife AreaDouglas County

- 2 Pole and Line Fishing Only (1)
 All Fish - 6 Fish Daily Creel Limit
 Channel Catfish - 12-15" Slot Length Limit (3)
 Large or Smallmouth Bass

Walton Park Lake, City of LitchfieldMontgomery County

- 2 Pole and Line Fishing Only (1)
 All Fish - 6 Fish Daily Creel Limit
 Channel Catfish

Warrior Lake, Moraine Hills State ParkMcHenry County

- 2 Pole and Line Fishing Only (1)
 All Fish - 6 Fish Daily Creel Limit
 Channel Catfish - 14" Minimum Length Limit
 Large or Smallmouth Bass - 3 Fish Daily Creel Limit
 Large or Smallmouth Bass (14)

Washington County Lake, Washington County Conservation AreaWashington County

- 2 Pole and Line Fishing Only (1)
 All Fish - 6 Fish Daily Creel Limit
 Channel Catfish - 14" Minimum Length Limit
 Large or Smallmouth Bass - 17" Minimum Length Limit
 Striped, White, or Hybrid - 3 Fish Daily Creel Limit
 Striped Bass (16)

Washington Park Lagoon, Chicago Park DistrictCook County

- 2 Pole and Line Fishing Only (1)
 All Fish - 6 Fish Daily Creel Limit
 Channel Catfish

Washington Park Pond, Springfield Park DistrictSangamon County

Trout - Fall Closed Season (10)
 Trout - Spring Closed Season (11)

Waverly Lake, City of WaverlyMorgan County

- 2 Pole and Line Fishing Only (1)
 All Fish - 6 Fish Daily Creel Limit
 Channel Catfish

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Large or Smallmouth Bass	- 15" Minimum Length Limit
Weinberg-King Pond, Weinberg-King State Park	
Schuyler County	
All Fish	- 2 Pole and Line Fishing Only (1)
Channel Catfish	- 6 Fish Daily Creel Limit
Weldon Springs Lake, Weldon Springs State Park	
Dewitt County	
All Fish	- 2 Pole and Line Fishing Only (1)
Channel Catfish	- 6 Fish Daily Creel Limit
Large or Smallmouth Bass	- 14" minimum Length Limit
West Frankfort New City Lake, City of West Frankfort	
Franklin County	
All Fish	- 2 Pole and Line Fishing Only (1)
Channel Catfish	- 6 Fish Daily Creel Limit
West Frankfort Old City Lake, City of West Frankfort	
Franklin County	
All Fish	- 2 Pole and Line Fishing Only (1)
Channel Catfish	- 6 Fish Daily Creel Limit
White Hall City Lake, City of White Hall	
Green County	
All Fish	- 2 Pole and Line Fishing Only (1)
Channel Catfish	- 6 Fish Daily Creel Limit
Whoopie-Cat-Lakey-Shawnee-National-Forest	
Hardin County	
All-Fish	- 2 Pole-and-line-Fishing-Only-(1)
Channel-Catfish	- 6-Fish-Daily-Creel-limit
Wilderness Lake, Moraine Hills State Park	
McHenry County	
All Fish	- 2 Pole and Line Fishing Only (1)
Channel Catfish	- 6 Fish Daily Creel Limit
Large or Smallmouth Bass	- 14" Minimum Length Limit
Large or Smallmouth Bass (14)	- 3 Fish Daily Creel Limit
Wilderness Pond, Fox Ridge State Park	
Coles County	
All Fish	- 2 Pole and Line Fishing Only (1)
Channel Catfish	- 6 Fish Daily Creel Limit
Large or Smallmouth Bass	- 14" Minimum Length Limit
William Powers Conservation Area	
Cook County	

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(Fishing from boats during waterfowl season unlawful. Fishing from shore in areas posted as waterfowl hunting areas during waterfowl season unlawful)

Wolf Lake, William W. Powers Conservation Area
Cook County

All Fish
Channel Catfish
Large or Smallmouth Bass
Walleye, Sauger, or Hybrid
Walleye

Woodford Co. Cons. Area (Fishing Ditch), Woodford County Conservation Area
Woodford County

(Unlawful to trespass upon designated waterfowl hunting areas 7 days prior to the waterfowl season and on areas designated as waterfowl refuges from October 10 until the end of the waterfowl season)

All Fish - 2 Pole and Line Fishing Only (1)
- 2 Pole and Line Fishing Only (1)
- 6 Fish Daily Creel Limit
- 14" Minimum Length Limit
- 14" Minimum Length Limit

Wyman Lake, City of Sullivan
Moultrie County

All Fish
Channel Catfish
Trout

Yellow Creek, State of Illinois
Stephenson County

Trout
(Source: Amended at 18 Ill. Reg. _____, effective _____, FEB 28 1994)
- Spring Closed Season(11)
- Spring Closed Season(11)

Section 810.70 Free Fishing Days

During the period of June 17-127-13-and-14-1993 10, 11, 12 and 13, 1994, it shall be legal for any person to fish in waters wholly or in part within the jurisdiction of the State, including the Illinois portion of Lake Michigan, without possessing a sport fishing license or salmon stamp.

(Source: Amended at 18 Ill. Reg. _____, effective _____, FEB 28 1994)

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NOTICE OF PROPOSED RULES

1) Heading of the Part: Certification of Individuals to Perform Industrial Radiography

2) Code Citation: 32-111. Adm. Code 405

3) Section Number:

405.10 New Section
405.20 New Section
405.30 New Section
405.40 New Section
405.50 New Section
405.60 New Section
405.70 New Section
405.80 New Section
405.90 New Section
405.100 New Section
405.110 New Section
405.120 New Section
405.130 New Section
405.140 New Section
405.150 New Section
405. APPENDIX A

4) Statutory Authority: Implementing and authorized by Section 7a of the Radiation Protection Act of 1990 (111. Rev. Stat. 1991, ch. 111 1/2, par. 210-7a) [420 ILCS 40/7a].

5) A Complete Description of the Subjects and Issues Involved: The Department is proposing this rule to implement Section 7a of the Radiation Protection Act of 1990, by establishing a program for the certification and renewal of certification of persons who use sources of ionizing radiation (e.g., radioactive materials or radiation machines) to perform industrial radiography for the purpose of macroscopic non-destructive examination of material and fabrication processes. The rule, as proposed, establishes: (1) minimum standards for training and experience for persons who perform industrial radiography; (2) application and examination requirements for certification and renewal of certification; (3) standards for recognition of certification and renewal by another State or jurisdiction; (4) provisions for suspension or revocation of certification; and (5) civil penalties. Under the proposed rules, the certification requirements would not apply to persons who perform radiographic procedures using Lixiscopes or cabinet x-ray systems.

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6) Will this proposed rule replace an emergency rule currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this proposed rule contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: The requirements imposed by the proposed rulemaking are not expected to require local governments to establish, expand, or modify their activities in such a way as to necessitate additional expenditures from local revenues.

11) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Comments on this proposed rulemaking may be submitted in writing for a period of 45 days following publication of this notice. The Department will consider fully all written comments on this proposed rulemaking submitted during the 45 day comment period. Comments should be submitted to:

Valerie Puccini
Staff Attorney
Department of Nuclear Safety
1035 Outer Park Drive
Springfield, Illinois 62704
(217) 785-9881 (voice)
(217) 782-6133 (TDD)

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: The requirements of this Part may have an impact on small businesses that provide industrial radiography services in Illinois since such business will be required to use only individuals who are certified pursuant to this Part to perform industrial radiography. In order to minimize the impact on all industrial radiography services, this Part allows experienced radiographers to become provisionally certified in advance of passing the written examinations required of certified industrial radiographers. This Part also contains a procedure for certifying industrial radiographer trainees. In addition, this Part provides for recognition of certain certifications issued out of-state.

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B) Reporting, bookkeeping or other procedures required for compliance: In order to comply with the requirements of this Part, individuals who perform industrial radiography will have to satisfy the training and testing requirements set forth in this Part. Individuals who were employed as industrial radiographers before September 1, 1994, may continue to perform industrial radiography procedures prior to satisfying the training and testing requirements provided that such individuals apply to the Department for provisional certification on or before September 1, 1994. Provisional certification shall be valid for two years.

C) Types of professional skills necessary for compliance: In order to become a certified industrial radiographer, an individual must possess knowledge and skills necessary to perform industrial radiography procedures in a manner that will not pose a threat to his/her safety or to the safety of others. This Part requires individuals to pass a written examination to demonstrate that they possess the requisite knowledge and skills. Individuals who were employed as industrial radiographers prior to September 1, 1994, may obtain provisional certification, which allows them to continue to perform industrial radiography, for up to two years, prior to passing the written examination. Certified industrial radiographers must take and pass the examination at 5 years intervals to maintain their certification.

The full text of the Proposed Rules begins on the next page:

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TITLE 32: ENERGY
CHAPTER II: DEPARTMENT OF NUCLEAR SAFETY
SUBCHAPTER b: RADIATION PROTECTION

PART 405
CERTIFICATION OF INDIVIDUALS TO PERFORM INDUSTRIAL RADIOGRAPHY

Section	Purpose and Scope
405.10	Definitions
405.20	Application for Certification
405.30	Categories of Certification
405.40	Examination Requirements
405.50	Examinations
405.60	Approved Training Program
405.70	Experience Requirements for Certification
405.80	Requirements for Issuance of Certification
405.90	Duration of Certification
405.100	Fees
405.110	Reciprocity
405.120	Requirements for Renewal of Certification
405.130	Suspension and Revocation of Certification
405.140	Civil Penalties
405.150	Minimum Training Requirements for Industrial Radiography
405.160	Applicable to Radioactive Materials and Radiation Machines

AUTHORITY: Implementing and authorized by Section 7(a) of the Radiation Protection Act of 1990 (Ill. Rev. Stat. 1991, ch. 111 1/2, par. 210-7a) [420 ILCS 40/7a].

SOURCE: Adopted at _____ Ill. Reg., effective _____.

Section 405.10 Purpose and Scope

- a) This Part establishes a program to certify persons to perform industrial radiography. Specifically, this Part provides:
- 1) Minimum standards for training and experience for persons who perform industrial radiography;
 - 2) Application and examination requirements for certification and recertification;

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- 3) Standards for the recognition of certification by other parties;
- 4) Provisions for the suspension or revocation of certification; and
- 5) Civil penalties.

b) This Part applies to any person who performs industrial radiography in this State.

Section 405.20 Definitions

As used in this Part, the following definitions shall apply:

"Act" means the Radiation Protection Act of 1990 (Ill. Rev. Stat. 1991, ch. 111 1/2, par. 210-1 et seq.) [420 ILCS 40].

"Approved Training Program" means a program that the Department has determined is adequate to prepare individuals to meet the training requirements prescribed in Section 405. Appendix A.

"Cabinet x-ray system" means an x-ray system with the x-ray tube installed in an enclosure which, independent of existing architectural structures except the floor on which it may be placed, is intended to contain at least that portion of a material being irradiated, provide radiation attenuation and exclude personnel from its interior during generation of x radiation. Included are all x-ray systems designed primarily for the inspection of carry-on baggage at airline, railroad, bus terminals and similar facilities. An x-ray tube used within a shielded part of a building or x-ray equipment which may temporarily or occasionally incorporate portable shielding is not considered a cabinet x-ray system.

"Certification" means the authorization by the Illinois Department of Nuclear Safety of an individual to perform industrial radiography in Illinois.

"Certified Industrial Radiographer" means an individual who has met prescribed training and experience requirements and has passed an approved examination and is authorized by the Department, pursuant to Section 405.90(a), to perform industrial radiography.

"Certified Industrial Radiographer Trainee" means an individual who is authorized by the Department, pursuant to Section 405.90

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(b), to be instructed in industrial radiography and who may perform industrial radiography while under the personal supervision of a Certified Industrial Radiographer or an approved Provisionally Certified Industrial Radiographer.

"Department" means the Illinois Department of Nuclear Safety.

"Director" means the Director of the Illinois Department of Nuclear Safety.

"Industrial Radiography" means the process used to perform the examination of the macroscopic structure of materials by non-destructive methods using radioactive materials or radiation machines. For purposes of this Part, industrial radiography does not include radiography performed with Lixiscopes or cabinet x-ray systems.

"Industrial Radiography - Radiation Machines" means the process of performing industrial radiography using radiation producing machines.

"Industrial Radiography - Radioactive Materials" means the process of performing industrial radiography using radioactive materials.

"Lixiscope" means a portable light-intensified imaging device using a sealed source.

"Provisionally Certified Industrial Radiographer" means an individual who was employed as an industrial radiographer prior to January 1, 1993, and who is authorized by the Department, pursuant to Section 405.90(c), to perform industrial radiography.

"Personal supervision" means supervision provided by a Certified Industrial Radiographer or an approved Provisionally Certified Industrial Radiographer who is physically present at the immediate site where sources of radiation and associated equipment are being used, visually evaluating the performance of the Certified Industrial Radiographer Trainee and in such proximity that immediate assistance can be given if required.

"Radiographic exposure device" means any instrument containing a sealed source fastened or contained therein, in which the sealed source or shielding thereof may be moved, or otherwise changed, from a shielded to unshielded position for purposes of making a radiographic exposure.

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Section 405.30 Application for Certification

- a) Any individual applying to the Department for certification to perform industrial radiography shall:
- 1) Submit a complete and legible application on a form prescribed by the Department;
 - 2) Pay the appropriate non-refundable application fee in accordance with Section 405.110;
 - 3) Meet the examination requirements set forth in Section 405.50 or satisfy the requirements for certification based on reciprocity as set forth in Section 405.120; and
 - 4) Provide evidence that the requirements for the given category and class for which certification is sought have been met.
- b) Any individual who seeks Provisional Certification as an industrial radiographer shall submit an application to the Department no later than September 1, 1994.
- c) The appropriate fee shall accompany the application when filing with the Department. An application shall be deemed filed on the date that it is received by the Department or on the date that it is postmarked by the United States Postal Service.

Section 405.40 Categories of Certification

- a) The Department shall certify individuals to perform industrial radiography in one or more of the following categories:
- 1) Certified Industrial Radiographer;
 - 2) Provisionally Certified Industrial Radiographer; or
 - 3) Certified Industrial Radiographer Trainee.
- b) Each certification issued shall include a class endorsement for the type of industrial radiography authorized. Such class endorsements are limited to:
- 1) Radioactive Materials;
 - 2) Radiation Machines; or

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3) Radioactive Materials and Radiation Machines.

Section 405.50 Examination Requirements

- a) An individual who seeks certification as a Certified Industrial Radiographer must have passed, prior to application for certification, a written examination appropriate to the category and class of certification sought in accordance with Section 405.60. An individual seeking certification as a Certified Industrial Radiographer after September 1, 1995, must pass, within 12 months prior to application for certification, a written examination appropriate to the category and class of certification sought in accordance with Section 405.80. In the event that this examination is not passed, the individual seeking certification as a Certified Industrial Radiographer may apply, during this 12 month period, for re-examination in accordance with subsection (d) below.
- b) An individual who holds certification as a Certified Industrial Radiographer Trainee shall take the examination for Certified Industrial Radiographer as prescribed by Section 405.60 within 12 months of certification. In the event that this examination is not passed, the Certified Industrial Radiographer Trainee may apply for re-examination in accordance with subsection (d) below.
- c) An individual who is a Provisionally Certified Industrial Radiographer shall take the examination for Certified Industrial Radiographer as prescribed by Section 405.60 on or before September 1, 1995. In the event that this examination is not passed, the Provisionally Certified Industrial Radiographer may apply for re-examination in accordance with subsection (d) below.
- AGENCY NOTE: In the event the provisionally certified industrial radiographer does not comply with application or testing requirements of subsection (c) above, certification as Provisionally Certified Industrial Radiographer shall expire on September 1, 1995.
- d) Application for examination or re-examination shall be on forms prescribed by the Department and shall include the appropriate fee specified by Section 405.110. Examination fees shall be non-refundable.
- e) Examinees shall present photographic identification (e.g., drivers license) at the time of examination.

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Section 405.60 Examinations

a) The Department shall administer examinations in each class of industrial radiography as specified in Section 405.40(b) at such times and places as the Department determines necessary.

1) The examination shall be available through the Conference of Radiation Control Program Directors, Inc.

2) The scaled passing score shall be 70 percent.

3) A candidate who fails an examination may apply for re-examination in accordance with Section 405.50.

b) The Department shall accept alternative examinations provided that such examinations are found acceptable by the U.S. Nuclear Regulatory Commission.

Section 405.70 Approved Training Program

Industrial radiographer training programs shall be approved by the Department. The Department shall base its approval on information provided by the training program that shall include:

- Curriculum information sufficient to assure inclusion of subjects referenced in Section 405.Appendix A;
- Copies of test questions and answers and other evaluation tools and criteria used to demonstrate a participant's comprehension of subject matter in Section 405.Appendix A; and
- Resumes of instructors.

Section 405.80 Experience Requirements for Certification

Applicants for certification to perform industrial radiography shall have a minimum of experience appropriate to each category and class of industrial radiography as follows:

a) Certified Industrial Radiographer

- Radioactive Materials 200 hrs
- Radiation Machines 120 hrs

3) Both Radioactive Materials and Radiation 320 hrs
Machines of which not less than 200 hours shall be with radioactive materials and not less than 120 hours shall be with radiation machines.

b) Provisionally Certified Industrial Radiographer

1) Employment as an industrial radiographer prior to September 1, 1994; and

2) Compliance with the requirements of 32 Ill. Adm. Code 350.2010(a).

c) Certified Industrial Radiographer Trainee. No prior experience required.

Section 405.90 Requirements for Issuance of Certification

The Department shall certify in a category and class of industrial radiography any individual who has satisfied the following requirements:

a) Certified Industrial Radiographer

1) Submitted an application for certification on a form prescribed by the Department;

2) Submitted the application fee specified in Section 405.110(a);

3) Passed an examination as required by Section 405.50(a) or satisfies the requirements for certification based on reciprocity as set forth in Section 405.120; and

4) Completed the required hours of experience in industrial radiography as specified in Section 405.80 or satisfies the requirements for certification based on reciprocity as set forth in Section 405.120.

b) Certified Industrial Radiographer Trainee

1) Submitted an application for certification on a form prescribed by the Department;

2) Submitted the application fee specified in Section 405.110(a); and

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- 3) Submitted documentation of successful completion of an approved training program as specified in Section 405.70 or satisfies the requirements for certification based on reciprocity as set forth in Section 405.120.
- c) Provisionally Certified Industrial Radiographer
- 1) No later than September 1, 1994, submitted an application for certification on a form prescribed by the Department;
 - 2) Submitted the application fee specified in Section 405.110(a); and
 - 3) Submitted documentation that prior to September 1, 1994, the individual was employed as an industrial radiographer and has complied with the requirements of 32 Ill. Adm. Code 350.2010(a).

AGENCY NOTE: Examples of acceptable documentation are a written statement from an employer that the applicant is or has been employed as an industrial radiographer or a copy of a radioactive materials license, issued by the Department or by the regulatory agency having jurisdiction in another state, identifying the applicant as an authorized user of industrial radiography sources.

Section 405.100 Duration of Certification

- a) The duration of certification issued by the Department shall be:
- 1) Certified Industrial Radiographer 5 years
 - 2) Certified Industrial Radiographer Trainee 2 years
 - 3) Provisionally Certified Industrial Radiographer
- Certification as a Provisionally Certified Industrial Radiographer, issued pursuant to Section 405.90(c) shall expire on September 1, 1996, provided that the application and testing requirements of Section 405.50(c) have been met. In the event the provisionally certified industrial radiographer does not comply with application or testing requirements of Section 405.50(c), certification as Provisionally Certified Industrial Radiographer shall expire on September 1, 1995.

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- b) Certification for Provisionally Certified Industrial Radiographer and Certified Industrial Radiographer Trainee are nonrenewable.
- Section 405.110 Fees
- a) The application fees for examination or certification shall be non-refundable and shall be as follows:
- 1) Each application for examination by the Department \$75.00
 - 2) Each application for certification:
 - A) Certified Industrial Radiographer \$50.00
 - B) Certified Industrial Radiographer Trainee \$50.00
 - C) Provisionally Certified Industrial Radiographer \$50.00
 - b) The appropriate fees shall accompany the application when filing with the Department.

Section 405.120 Reciprocity

- a) The Department shall issue certification to an applicant who has been certified in another state or jurisdiction provided that:
- 1) The applicant holds a valid certification in the appropriate category and class issued by another state or jurisdiction;
 - 2) The standards and procedures for certification in the state or jurisdiction that issued the certification are the same or comparable to the certification standards established by the Radiation Protection Act of 1990 and this Part;
 - 3) The applicant presents a copy of the certification document issued by the other state or jurisdiction to the Department; and
 - 4) The applicant submits the application fee in accordance with Section 405.110(a).
- b) Individuals who are certified by reciprocity shall either:

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- 1) Maintain the certification upon which the reciprocal certification was issued; or
- 2) Satisfy the requirements of Section 405.90 prior to the expiration of the certification upon which reciprocal certification was issued.

Section 405.130 Requirements for Renewal of Certification

a) Prerequisites

- 1) An individual shall submit an application for re-examination and renewal of certification at least six months prior to the expiration date of certification. The Department shall waive this requirement if the applicant satisfies the requirements of Section 405.30(a). An individual may not legally perform industrial radiography without valid certification.

- 2) Each applicant shall submit a complete and legible application with the fee for re-examination and renewal of certification in accordance with Section 405.30(a).

- b) Re-examination. Applicants for renewal of certification shall meet the requirements of Section 405.90(a) including re-examination as described in subsection (a) above.

- c) Certification as a Provisionally Certified Industrial Radiographer is nonrenewable.

- d) Certification as a Certified Industrial Radiography Trainee is nonrenewable.

Section 405.140 Suspension and Revocation of Certification

- a) The Department shall act to suspend or revoke an individual's certification for any one or a combination of the following causes:

- 1) Knowingly causing a material misstatement or misrepresentation to be made in the application for initial certification or renewal of certification if such misstatement or misrepresentation would impair the Department's ability to assess and evaluate the applicant's qualifications for certification pursuant to this Part;

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- 2) Knowingly falsifying records of employees when such falsification would impair the Department's ability to assess and evaluate the applicant's qualifications for certification pursuant to this Part;
 - 3) Willfully evading the statute or regulations pertaining to certification, or willfully aiding another person in evading such statute or regulations pertaining to certification;
 - 4) Having been convicted of a crime which is a felony under the laws of this State or conviction of a felony in a federal court, unless such individual demonstrates to the Department that he/she has been sufficiently rehabilitated, by restoration of all civil rights, to warrant the public trust;
 - 5) Exhibiting significant or repeated incompetence in the performance of industrial radiography duties;
 - 6) Having a physical or mental illness or disability that results in the individual's inability to perform industrial radiography duties with reasonable judgment, skill and safety;
 - 7) Performing industrial radiography in such a manner that requirements of 32 Ill. Adm. Code 350 are violated resulting in a threat to health and safety of the individual, other workers or to the public;
 - 8) Repeatedly using alcohol, narcotics or stimulants to such an extent as to impair the performance of duties;
 - 9) Having had a similar certification suspended or revoked if the grounds for that suspension or revocation are the same or equivalent to one or more grounds for suspension or revocation as set forth herein; and
 - 10) Failure to maintain the out-of-state certification upon which certification by reciprocity was issued.
- b) If, based upon any of the above grounds, the Department determines that action to suspend or revoke certification is warranted, the Department shall notify the individual and shall provide an opportunity for a hearing in accordance with 32 Ill. Adm. Code 200.60. An opportunity for a hearing shall be provided before the Department takes action to suspend or revoke an individual's

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certification unless the *Department finds that an immediate suspension of certification is required to protect against immediate danger to the public health or safety*, (see Section 38 of the Act), in which case the Department shall suspend an individual's certification pending a hearing.

- c) If the Department finds that removal of certification is warranted, the usual action shall be a suspension of certification for up to one year. The term of suspension may be reduced by the Director, upon the recommendation of the hearing officer, if the hearing officer finds, based upon evidence presented to him/her during a hearing, that the conditions leading to the Preliminary Order for Suspension can be cured in less than one year. However, if the Department finds that the causes are of a serious or continuous nature, such as past actions which posed an immediate threat to occupational or public health or safety or deficiencies that cannot be cured within one year, the Department shall revoke the individual's certification.
- d) When an individual's certification is suspended or revoked, the individual shall surrender his/her certification document to the Department until the termination of the suspension period or until reissuance of the certification.
- e) An individual whose certification has been revoked may seek reinstatement of certification by filing a petition for reinstatement with the Department which complies with the requirements of 32 Ill. Adm. Code 200.40. Such petition may be filed one year or more after the beginning of the revocation period. The individual shall be afforded a hearing in accordance with 32 Ill. Adm. Code 200 and shall bear the burden of proof of establishing that the certification should be reinstated due to rehabilitation or other just cause.

Section 405.150 Civil Penalties

- a) The Department shall assess civil penalties, in accordance with subsection (c) below, against any individual who performs industrial radiography without valid certification.

AGENCY NOTE: Licensees and registrants that allow individuals who are not certified to perform industrial radiography are also subject to civil penalties. These penalties are assessed pursuant to 32 Ill. Adm. Code 310.

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- b) Prior to assessing civil penalties, the Department shall confirm the violation of the certification requirements by:
 - 1) Observation of the violation by a Department inspector;
 - 2) Obtaining records, documents or other physical evidence;
 - 3) Obtaining statements from either the employer, or the employee which confirm the existence of the violation; or
 - 4) Obtaining statements from third parties, e.g., Nondepartment Inspectors or co-workers, that corroborate the allegation that a violation has occurred.
- c) Civil penalties shall be assessed against individuals who perform industrial radiography without certification (i.e., uncertified radiographer) as follows:
 - 1) First violation by an uncertified individual - \$250.
 - 2) Second violation by an uncertified individual - \$500.
 - 3) Third and subsequent violation by an uncertified individual - \$1,000 for each violation.
- d) The Department shall impose civil penalties by issuing a Preliminary Order and Notice of Opportunity for Hearing as provided in 32 Ill. Adm. Code 200.60. Each day the violation continues shall constitute a separate offense.

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Section 405. APPENDIX A Minimum Training Requirements for Industrial Radiography Applicable to Radioactive Material and Radiation Machines

- A) Fundamentals of Radiation Safety
 - 1) Characteristics of radiation
 - 2) Units of radiation dose and quantity of radioactivity
 - 3) Significance of radiation dose
 - a) Radiation protection standards
 - b) Biological effects of radiation
 - 4) Levels of radiation from sources of radiation
 - 5) Methods of controlling radiation dose
 - a) Working time
 - b) Working distances
 - c) Shielding
- B) Radiation Detection Instrumentation to be Used
 - 1) Use of radiation survey instruments
 - a) Operation
 - b) Calibration
 - c) Limitations
 - 2) Survey techniques
 - 3) Use of personnel monitoring equipment
 - a) Film badges
 - b) Thermoluminescent dosimeters
 - c) Pocket dosimeters

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- C) The Requirements of Pertinent Federal and State Regulations
- D) Written Operating and Emergency Procedures
- E) Case Histories of Radiation Accidents
- F) Radiography Equipment to be Used
 - 1) For Industrial Radiography Using Radioactive Material
 - a) Remote handling equipment
 - b) Radiographic exposure devices and sealed sources
 - c) Storage containers
 - d) Operation and control of radiography equipment
 - e) Demonstration of competency to safely perform radiographic procedures using a simulated source of radioactive material.
 - 2) For Industrial Radiography Using Radiation Machines
 - a) Remote exposure equipment
 - b) Radiation machine exposure equipment
 - c) Operation and control of radiography equipment
 - d) Demonstration of competency to safely perform radiographic procedures using a simulated source of radiation.

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1) Heading of the Part: RADIATION SAFETY REQUIREMENTS FOR WIRELINE SERVICE OPERATIONS AND SUBSURFACE TRACER STUDIES

2) Code Citation: 32 Ill. Adm. Code 351

3) Section Number: Adopted Action:

351.10 Amendment
351.25 New Section
351.40 Amendment
351.1010 Amendment
351.1040 Amendment
351.1050 Amendment
351.1060 Amendment
351.1070 Amendment
351.1080 Amendment
351.1090 Amendment
351.1100 Amendment
351.2010 Amendment
351.2020 Amendment
351.2030 Amendment
351.3030 Amendment
351.3040 Amendment
351.4010 Amendment
351.4020 Amendment
351.4030 Amendment
351.5010 Amendment
351. APPENDIX B

4) Statutory Authority: Implementing and authorized by Sections 9 and 11 of the Radiation Protection Act of 1990 (Ill. Rev. Stat. 1991, ch. 111½, par. 210-9 and 210-11) [420 ILCS 40/9 and 11], and Section 5 of the Personnel Radiation Monitoring Act (Ill. Rev. Stat. 1991, ch. 111½, pars. 230.15) [420 ILCS 25/5].

5) Effective Date of Amendments: **FEB 2 1994**

6) Does this rulemaking contain an automatic repeal date? No

7) Does this amendment contain incorporations by reference? Yes

8) Date filed in Agency's Principal Office: February 17, 1994

9) Notice of Proposal Published in the Illinois Register:

June 18, 1993 (17 Ill. Reg. 8674)

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10) Has JCAR issued a Statement of Objections to these Amendments? No

11) Differences between proposal and final version:

- a) In the Table of Content, by inserting "351.25 Incorporations by Reference" and in Section 351.5010, by deleting the comma after the word "Abandonment".
- b) In the Authority Note, on line 1, by deleting "40/" immediately before the "9" and "11"; on line 3, by deleting "40/" after the word "and", by deleting "25/" after the word "Section"; and on line 5, by changing "[420 ILCS 25/0.01 - 25/5]" to "[420 ILCS 25/5]".
- c) In Section 351.10, on line 3, by deleting the comma after the word "markers".
- d) By inserting a new Section as follows:
"Section 351.25 Incorporations by Reference
All rules, standards and guidelines of agencies of the United States or nationally recognized organizations or associations that are incorporated by reference in this Part are incorporated as of the date specified in the reference and do not include any later amendments or editions. Copies of these rules, standards and guidelines that have been incorporated by reference are available for public inspection at the Department of Nuclear Safety, 1035 Outer Park Drive, Springfield, Illinois. ".
In Section 351.40, on line 4 of the lead in paragraph, by deleting the comma after the word "contractor";
in subsection (b), on line 2, by changing "down-hole" to "downhole".
- e) In Section 351.1010, on line 1, by deleting the comma after the word "stored".
- f) In Section 351.1040:
in subsection (a), on line 6, by changing "μR" to "microR"; and on line 7, by changing "μC/kg" to "microC/kg".
- g) In Section 351.1060, on line 8, by deleting the comma after the word "inventory".

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- i) In Section 351.1070(a), on line 1, by deleting the comma after the word "number".
- j) In Section 351.1080(a)(3), by deleting the AGENCY NOTE.
- k) In Section 351.1090:
 - in subsection (a), on line 1, by deleting the comma after the word "holders";
 - in subsection (a)(1), on line 1, by deleting the comma after the word "holder"; on line 2, by deleting the comma after the word "legible"; on line 6, by deleting the comma after the word "requirement"; and by deleting "*" after the word "DANGER" and before the word "AGENCY";
 - in subsection (b), on line 2, by deleting the comma after the word "legible"; and by deleting "*" after the word "DANGER" and before the word "AGENCY".
- l) In Section 351.1100:
 - in subsection (a), on line 4, by deleting the comma after the word "containers";
 - in subsection (c), on line 1, by deleting the comma after the word "opening"; and on line 4, by deleting the comma after the word "State".
- m) In Section 351.2010:
 - in subsection (a)(2), on line 3, by deleting the comma after the number "340"; and on line 6, by deleting the comma after the word "procedures";
 - in subsection (a)(3), on line 3, by deleting the comma after the word "tools";
 - in subsection (b)(2), on line 4, by deleting the comma after the word "tools".
- n) In Section 351.2020:
 - in subsection (e), on line 3, by deleting the comma after the word "vehicles";

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- in subsection (i), on line 2, by deleting the comma after the word "containers";
- in subsection (k), on line 1, by deleting the comma after the word "receiving".
- o) In Section 351.3030:
 - in subsection (b)(1), on line 5, by changing the comma to a semi-colon after the number "604";
 - in subsection (b)(2)(A), on line 6, by changing the comma to a semi-colon after the number "240"; and by deleting the AGENCY NOTE;
 - in subsection (b)(2)(B), on line 4, by changing the comma to a semi-colon after the number "704".
- p) In Section 351.4010:
 - in subsection (d), on line 3, by deleting the comma after the number "14";
 - in subsection (e), on line 4, by deleting the comma after the word "used".
- q) In Section 351.4020(a), on line 1, by deleting the comma after the word "registration"; and on line 3, by deleting the comma after the word "State".
- r) In Section 351.4030(e), on line 3, by deleting the comma after the word "registration".
- s) In Section 351.5010:
 - in subsection (a), on line 6, by deleting the comma after the word "missing";
 - in subsection (c)(1)(A), on line 2, by changing the comma to a semi-colon after the word "plug";
 - in subsection (c)(1)(B), on line 2, by changing the comma to a semi-colon after the word "device";

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- in subsection (c)(2), on line 3, by deleting the comma after the word "loss";
- in subsection (c)(3)(C), on line 1, by deleting the comma after the word "location";
- in subsection (f), on line 7, by deleting the comma after the word "loss".
- t) In Section 351.Appendix B, on line 1, by changing "SECTION" to "Section".

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? The Joint Committee on Administrative Rules did not issue an agreement letter for this Part.

13) Will these amendments replace an emergency amendment currently in effect? No

14) Are there any amendments pending on this Part? No

15) Summary and Purpose of Amendments: The Amendment will: (a) modify this Part to include both metric and English units of measurements; (b) modify statutory citations so that they refer to the Illinois Compiled Statutes; and make non-substantive editorial changes. The Department is also adding a new Section 351.25, "Incorporations by Reference". This new Section sets forth general information regarding rules, standards and guidelines that are incorporated into Part 351 by reference. In addition, in Sections 351.1040, 351.1060, 351.1090, 351.3040 and 351.5010, the Department has changed the cross-references to specific sections of 32 Ill. Adm. Code 340. Lastly, the Department is proposing to delete the language in Section 351.1050 regarding leak testing and replace it with a cross reference to 32 Ill. Adm. Code 340.410 regarding testing for leakage or contamination of sealed sources.

16) Information and questions regarding these amendments shall be directed to:

Valerie Puccini
Staff Attorney
Department of Nuclear Safety
1035 Outer Park Drive
Springfield, Illinois 62704
(217) 785-9881 (voice)
(217) 785-9900 (TDD)

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The full text of the Adopted Amendments begins on the next page:

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TITLE 32: ENERGY
CHAPTER II: DEPARTMENT OF NUCLEAR SAFETY
SUBCHAPTER b: RADIATION PROTECTION

PART 351
RADIATION SAFETY REQUIREMENTS FOR WIRELINE
SERVICE OPERATIONS AND SUBSURFACE TRACER STUDIES

Section 351.10 Purpose
351.20 Scope
351.25 Incorporations by Reference
351.30 Definitions
351.40 Prohibition
351.1010 Limits on Levels of Radiation
351.1020 Storage Precautions
351.1030 Transport Precautions
351.1040 Radiation Survey Instruments
351.1050 Leak Testing for Leakage or Contamination of Sealed Sources
351.1060 Quarterly Inventory
351.1070 Utilization Records
351.1080 Design and Performance Criteria for Sealed Sources Used in Downhole Operations
351.1090 Labeling
351.1100 Inspection and Maintenance
351.2010 Training Requirements
351.2020 Operating and Emergency Procedures
351.2030 Personnel Monitoring
351.3010 Security
351.3020 Handling Tools
351.3030 Subsurface Tracer Studies
351.3040 Particle Accelerators
351.4010 Radiation Surveys
351.4020 Documents and Records Required at Field Stations
351.4030 Documents and Records Required at Temporary Jobsites
351.5010 Notification of Incidents, Abandonment and Lost Sources
APPENDIX A Subjects To Be Included In Training Courses For Logging Supervisors
APPENDIX B Example of Plaque for Identifying Wells Containing Sealed Sources Containing Radioactive Material Abandoned Downhole

AUTHORITY: Implementing and authorized by Sections 9 and 11 of the Radiation Protection Act of 1990 (Ill. Rev. Stat. 1991, ch. 111 1/2, pars. 210.9 and 210.11) [420 ILCS 40/9 and 11] and Section 5 of the Personnel Radiation Monitoring Act (Ill. Rev. Stat. 1991, ch. 111 1/2, par. 230.15) [420 ILCS 25/5].

SOURCE: Adopted at 10 Ill. Reg. 17507, effective September 25, 1986; amended at 11 Ill. Reg. 5215, effective March 13, 1987; amended at 13 Ill. Reg. 11605,

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effective August 11, 1989; amended at 14 Ill. Reg. 13633, effective August 13, 1990; amended at 18 Ill. Reg. _____, effective FEB 2 2 1994.

Section 351.10 Purpose

The regulations in this Part establish requirements for persons including individuals using sources of radiation for wireline service operations, including mineral logging, radioactive markers and subsurface tracer studies. The requirements of this Part are in addition to, and not in substitution for, the requirements of 42 Ill. Adm. Code: 3107-3207 3307-3407 and 400 Chapter II, Subchapters b and d.

(Source: Amended 18 Ill. Reg. _____, effective FEB 2 2 1994)

Section 351.25 Incorporations by Reference

All rules, standards and guidelines of agencies of the United States or nationally recognized organizations or associations that are incorporated by reference in this Part are incorporated as of the date specified in the reference and do not include any later amendments or editions. Copies of these rules, standards and guidelines that have been incorporated by reference are available for public inspection at the Department of Nuclear Safety, 1035 Outer Park Drive, Springfield, Illinois:

(Source: Added at 18 Ill. Reg. _____, effective FEB 2 2 1994)

Section 351.40 Prohibition

No licensee or registrant shall perform wireline service operations with a sealed source(s) unless, prior to commencement of the operation, the licensee has a written agreement with the well operator, well owner, drilling contractor or land owner that:

- in the event a sealed source is lodged downhole, efforts at recovery will be made that are commensurate with the circumstances of the specific case, e.g., quantity and half-life of the isotope, depth of the source and presence of potable water aquifers; and
- In the event a decision is made to abandon the sealed source downhole, the requirements of Section 351.5010(c) shall be met within 30 days after a decision by the licensee to abandon the source has been approved by the Department of Nuclear Safety (Department).

(Source: Amended 18 Ill. Reg. _____, effective FEB 2 2 1994)

Section 351.1010 Limits on Levels of Radiation

Sources of radiation shall be used, stored and transported in such a manner

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that the transportation requirements of 32 Ill. Adm. Code 340.341 and the dose limitation requirements of 32 Ill. Adm. Code 340 are met.

(Source: Amended at 18 Ill. Reg. _____, effective _____,
FEB 22 1994)

Section 351.1040 Radiation Survey Instruments

- a) The licensee or registrant shall maintain sufficient calibrated and operable radiation survey instruments at each field station to make physical radiation surveys as required by this Part and by 32 Ill. Adm. Code 340.510(a). Instrumentation shall be capable of measuring 0.1-microR/h to 25.8 mCi/kg (25.8 μ Ci/kg, 1100 μ R/h) per hour through at least 20-microR/h (20 mR) per hour.
- b) Each radiation survey instrument shall be calibrated:
 - 1) at 6-month intervals not to exceed six (6) months and after each instrument servicing (e.g., electronic repair);
 - 2) at 6-month intervals and radiation levels equivalent to those to be encountered during use; and
 - 3) so that accuracy within plus or minus 20 percent of the true radiation level can be demonstrated on each scale.
- c) Calibration records shall be maintained for a period of two (2) years for inspection by the Department.

(Source: Amended at 18 Ill. Reg. _____, effective _____,
FEB 22 1994)

Section 351.1050 Leak-Testing for Leakage or Contamination of Sealed Sources

- a) Requirements: Each licensee or registrant using sealed sources of radioactive material shall have the sources tested for leakage. Records of leak test results shall be kept in units of microcuries and maintained for inspection by the Department for two (2) years after the next required leak test is performed or until transfer or disposal of the sealed source.
- b) Method of testing: Tests for leakage shall be performed only by persons specifically authorized to perform such tests by the Department, the U.S. Nuclear Regulatory Commission, an Agreement State or a Licensing State. The test sample shall be taken from the surface of the source holder, or from the surface of the device in which the source is stored or mounted and on which one might expect contamination to accumulate. The test sample shall be analyzed for radioactive contamination, and the analysis shall be capable of detecting the presence of 0.005 microcurie (0.005 μ Ci) of radioactive material on the test sample.
- c) Interval of testing: Each sealed source of radioactive material shall be tested at intervals not to exceed six (6) months. In the absence of a certificate from a transferor indicating that a test has been made

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prior to the transfer, the sealed source shall not be put into use until tested; if, for any reason, it is suspected that a sealed source may be leaking, it shall be removed from service immediately and tested for leakage.

- d) leaking or contaminated sources: if the test reveals the presence of 0.005 microcurie (0.005 μ Ci) or more of leakage or contamination, the licensee shall immediately withdraw the source from use and shall cause it to be decontaminated, repaired, or disposed of in accordance with this Part. A report describing the equipment involved, the test results, and the corrective action taken shall be filed with the Department.
- e) Exemptions: The following sources are exempted from the periodic leak test requirements of Section 351.1050(a) through (d):
 - 1) hydrogen-3 sources;
 - 2) sources of radioactive material with a half-life of 30 days or less;
 - 3) sealed sources of radioactive material in gaseous form;
 - 4) sources of beta- and/or gamma-emitting radioactive material with an activity of 100 microcuries (0.1 μ Ci) or less; and
 - 5) sources of alpha-emitting radioactive material with an activity of 10 microcuries (0.01 μ Ci) or less.

Testing for leakage or contamination of sealed sources shall be performed in accordance with 32 Ill. Adm. Code 340.410. Test samples shall be taken from the surfaces of sources or source holders or from the surfaces of devices in which sources are mounted and on which one might expect contamination to accumulate.

(Source: Amended at 18 Ill. Reg. _____, effective _____,
FEB 22 1994)

Section 351.1060 Quarterly Inventory

Each licensee or registrant shall conduct a quarterly physical inventory to account for all sources of radiation. If all sources are not accounted for during the inventory, the licensee or registrant shall notify the Department in accordance with the requirements of 32 Ill. Adm. Code 340.402 340.1210. Records of inventories shall be maintained for two (2) years from the date of inventory for inspection by the Department and shall include the quantities and kinds of sources of radiation, the location where sources of radiation are assigned, the date of the inventory and the name of the individual conducting the inventory.

(Source: Amended at 18 Ill. Reg. _____, effective _____,
FEB 22 1994)

Section 351.1070 Utilization Records

Each licensee or registrant shall maintain current records, which shall be kept

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available for inspection by the Department for two-(2) years from the date of the recorded event, showing the following information for each source of radiation:

a) ~~make~~-Make, model number, and a serial number or a description of each source of radiation used;

b) ~~the~~-The identity of the well-logging supervisor or field unit to whom assigned;

c) ~~locations~~-Locations where used and dates of use; and

d) ~~in~~-in the case of tracer materials and radioactive markers, the utilization record shall indicate the radionuclide and activity used in a particular well.

(Source: Amended at 18 Ill. Reg. _____, effective _____, FEB 22 1994)

Section 351.1080 Design and Performance Criteria for Sealed Sources Used in Downhole Operations

- a) A licensee may not use a sealed source in well-logging unless:
- 1) ~~the~~-The sealed source is doubly encapsulated;
- 2) ~~the~~-The sealed source contains radioactive material whose chemical and physical forms are insoluble and non-dispersible; and
- 3) ~~a~~-A prototype of the sealed source has been tested and meets the performance standards for oil well-logging sources contained in either the United States of America Standards Institute (USASI) Standard No. N5.10-1968 or the American National Standards Institute (ANSI) Standard No. N542-1977 (1978 edition), exclusive of subsequent amendments or editions.
- ~~A copy of USASI Standard No. N5.10-1968 and ANSI Standard No. N542-1977 are available for public inspection at the Department's offices, 4045 Outer Park Drive, Springfield, Illinois.~~
- b) The requirements of subsection (a) above do not apply to sealed sources that contain licensed material in gaseous form.

(Source: Amended at 18 Ill. Reg. _____, effective _____, FEB 22 1994)

Section 351.1090 Labeling

- a) Sources, Source Holders or Logging Tools
- 1) Each source, source holder or logging tool containing radioactive material shall bear a durable, legible, and clearly visible marking or label which has, as a minimum, the standard radiation caution symbol (as described in 32 Ill. Adm. Code 340.2040 340.910), without the conventional color requirement, and the following wording:

DANGER
RADIOACTIVE

*AGENCY NOTE: or CAUTION.

2) This labeling shall be on every component transported as a separate piece of equipment.

b) Transport Containers: Each transport container shall have permanently attached to it a durable, legible and clearly visible label which has, as a minimum, the standard radiation caution symbol (as described in 32 Ill. Adm. Code 340.2040 340.910) and the following wording:

DANGER*

NOTIFY CIVIL AUTHORITIES (OR NAME OF COMPANY)
*AGENCY NOTE: or CAUTION.

(Source: Amended at 18 Ill. Reg. _____, effective _____, FEB 22 1994)

Section 351.1100 Inspection and Maintenance

- a) Each licensee or registrant shall conduct, at intervals not to exceed six-(6) months, a program of inspection and maintenance of source holders, logging tools, source handling tools, storage containers, transport containers, and injection tools to assure proper labeling and physical condition. Records of inspection and maintenance shall be maintained for a period of two-(2) years for inspection by the Department.
- b) If any inspection conducted pursuant to Section 351.1100(a) subsection (a) above reveals damage to labeling or components which could result in release of radioactive material into the environment, or loss of control of radioactive material, or which could otherwise create a risk of increase in radiation exposure, the device shall be removed from service until repairs have been made.
- c) The repair, opening or modification of any sealed source shall be performed only by persons specifically authorized to do so by the Department, the U.S. Nuclear Regulatory Commission, an Agreement State or a licensing State.

(Source: Amended at 18 Ill. Reg. _____, effective _____, FEB 22 1994)

Section 351.2010 Training Requirements

- a) No licensee or registrant shall permit any individual to act as a logging supervisor as defined in this Part until such individual has:
- 1) received-Received 40 hours of instruction in the subjects outlined in Appendix-A of this Part Section 351.2010 A and has demonstrated to the satisfaction of the licensee or registrant an understanding thereof by successful completion of a written examination administered by the licensee or registrant;
- 2) read Read and received instruction in the regulations contained

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in this Part and the applicable Sections of 32 Ill. Adm. Code 310, 340, and 400 or the equivalent state or federal regulations, conditions of appropriate license or certificate of registration, and the licensee's or registrant's operating and emergency procedures, and demonstrated to the satisfaction of the licensee or registrant an understanding thereof; and

3) ~~demonstrated~~-demonstrated to the satisfaction of the licensee or registrant competence to use sources of radiation, related handling tools, and radiation survey instruments which will be used on the job.

b) No licensee or registrant shall permit any individual to assist in the handling of sources of radiation until such individual has:

1) ~~read~~-read or received instruction in the licensee's or registrant's operating and emergency procedures and demonstrated to the satisfaction of the licensee or registrant an understanding thereof; and

2) ~~demonstrated~~-demonstrated to the satisfaction of the licensee or registrant competence to use, under the personal supervision of the logging supervisor, the sources of radiation, related handling tools, and radiation survey instruments which will be used on the job.

c) The licensee or registrant shall maintain employee training records for inspection by the Department for two--(2) years following termination of employment.

(Source: Amended at 18 Ill. Reg. _____, effective FEB 2 2 1994)

Section 351.2020 Operating and Emergency Procedures

The licensee's or registrant's operating and emergency procedures shall include instructions in at least the following:

a) ~~handling~~-Handling and use of sources of radiation to be employed so that no individual is likely to be exposed to radiation doses in excess of the standards established in 32 Ill. Adm. Code 340;

b) ~~methods~~-Methods and occasions for conducting radiation surveys;

c) ~~methods~~-Methods and occasions for locking and securing sources of radiation;

d) ~~personnel~~-Personnel monitoring and the use of personnel monitoring equipment;

e) ~~transportation~~-Transportation to temporary jobsites and field stations, including the packaging and placing of sources of radiation in vehicles, placarding of vehicles, and securing sources of radiation during transportation;

f) ~~minimizing~~-Minimizing exposure of individuals in the event of an accident;

g) ~~procedure~~-Procedure for notifying proper personnel in the event of an accident;

h) ~~maintenance~~-Maintenance of records;

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i) ~~inspection~~-Inspection and maintenance of source holders, logging tools, source handling tools, storage containers, transport containers, and injection tools;

j) ~~procedure~~-Procedure to be followed in the event a sealed source is lodged downhole; and

k) ~~procedures~~-Procedures to be used for picking up, receiving, and opening packages containing radioactive material.

(Source: Amended at 18 Ill. Reg. _____, effective FEB 2 2 1994)

Section 351.2030 Personnel Monitoring

a) No licensee or registrant shall permit any individual to act as a logging supervisor or to assist in the handling of sources of radiation unless each such individual wears either a film badge or a thermoluminescent dosimeter (TLD). Each film badge or TLD shall be assigned to and worn by only one individual.

b) ~~Personnel monitoring records shall be maintained for inspection until the Department authorizes disposition~~-Records of individual monitoring results shall be retained in accordance with 32 Ill. Adm. Code 340.1160.

(Source: Amended at 18 Ill. Reg. _____, effective FEB 2 2 1994)

Section 351.3030 Subsurface Tracer Studies

a) All personnel handling radioactive tracer material shall be required to use protective gloves, protective clothing and equipment which prevents the spread of contamination. Precautions shall be taken by the licensee or registrant to prevent ingestion or inhalation of radioactive material.

b) No licensee or registrant shall cause the injection of radioactive material into potable aquifers without specific license authorization issued by the Department pursuant to 32 Ill. Adm. Code 330.250. Such authorization will be issued only if:

1) The applicant's proposed procedures will prevent tracer concentrations at the most exposed drinking water source or public water supply inlet from exceeding the Illinois Environmental Protection Agency's drinking water quality standards in 35 Ill. Adm. Code 604.7; and

2) The applicant's proposed procedures will be performed:

A) on an underground injection well for which a U.S. Environmental Protection Agency underground injection control program permit has been issued pursuant to 40 CFR 124 or 40 CFR 144 revised as of July 1, 1988 ~~1990~~, or pursuant to 35 Ill. Adm. Code 705 or 62 Ill. Adm. Code 247; or

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- B) on-On a well for which the Illinois Environmental Protection Agency has otherwise approved a subsurface radioactive tracer study pursuant to 35 Ill. Adm. Code 704.72, or
- C) on-On a well for which the Illinois Department of Mines and Minerals has otherwise approved a subsurface radioactive tracer study pursuant to 62 Ill. Adm. Code 240.

(Source: Amended at 18 Ill. Reg. _____, effective _____, FEB 22 1994)

Section 351.3040 Particle Accelerators

No licensee or registrant shall permit above-ground testing of particle accelerators, designed for use in well-logging, which results in the production of radiation, except in areas or facilities controlled or shielded so that the requirements of 32 Ill. Adm. Code 340.1010 340.210 and 340.1050 340.310, as applicable, are met.

(Source: Amended at 18 Ill. Reg. _____, effective _____, FEB 22 1994)

Section 351.4010 Radiation Surveys

- a) Radiation surveys and/or calculations shall be made and recorded for each area where radioactive materials are stored.
- b) Radiation surveys and/or calculations shall be made and recorded for the radiation levels in occupied positions and on the exterior of each vehicle used to transport radioactive material. Such surveys and/or calculations shall include each source of radiation or combination of sources to be transported in the vehicle.
- c) After removal of the sealed source from the logging tool and before departing the jobsite, the logging tool detector shall be energized, or a radiation survey meter used, to assure that the logging tool is free of contamination.
- d) Radiation surveys shall be made and recorded at the jobsite or wellhead for each tracer operation, except those using Hydrogen, hydrogen, carbon, carbon 14, and sulfur sulfur 35. These surveys shall include measurements of radiation levels before and after the operation.
- e) Records required pursuant to Section 351.4010 subsections (a) through (d) above shall include the dates, the identification of individual(s) making the survey, the identification of survey instrument(s) used, and an exact description of the location of the survey. Records of these surveys shall be maintained for inspection by the Department for two (2) 5 years after completion of the survey.

(Source: Amended at 18 Ill. Reg. _____, effective _____, FEB 22 1994)

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Section 351.4020 Documents and Records Required at Field Stations

Each licensee or registrant shall maintain, for inspection by the Department, the following documents and records for the specific devices and sources used at the field station:

- a) appropriate-Appropriate license, certificate of registration or equivalent document issued by the Nuclear Regulatory Commission, an Agreement State or Licensing State;
- b) operating-Operating and emergency procedures required by Section 351.2020;
- c) 32 Ill. Adm. Code: 3107-3207-3307-3407-3417-351-and-400 Chapter 11, Subchapters b and d;
- d) records-Records of the latest survey instrument calibrations pursuant to Section 351.1040;
- e) records-of-the-3107-3207-3307-3407-3417-351-and-400-Section 341-1050-The dates of the latest tests for leakage or contamination performed on the sealed sources and the results of the tests;
- f) quarterly-Quarterly inventories required pursuant to Section 351.1060;
- g) utilization-Utilization records required pursuant to Section 351.1070;
- h) records-Records of inspection and maintenance required pursuant to Section 351.1100; and
- i) survey-Survey records required pursuant to Section 351.4010.

(Source: Amended at 18 Ill. Reg. _____, effective _____, FEB 22 1994)

Section 351.4030 Documents and Records Required at Temporary Jobsites

Each licensee or registrant conducting operations at a temporary jobsite shall have the following documents and records available at that site for inspection by the Department:

- a) operating-Operating and emergency procedures required by Section 351.2020;
- b) survey-Survey records required pursuant to Section 351.4010 for the period of operation at the site;
- c) evidence-Evidence of current calibration for the radiation survey instruments in use at the site;
- d) the-The licensee's radioactive material license, including all appropriate amendments;
- e) when-When operating in the State under reciprocity as provided for in 32 Ill. Adm. Code 330.900, a copy of the appropriate license, certificate of registration or equivalent document(s); and
- f) the-The date dates of the latest test tests for leakage and or contamination performed on the sealed source(s) and the results of the test(s).

(Source: Amended at 18 Ill. Reg. _____, effective _____, FEB 22 1994)

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Section 351.5010 Notification of Incidents, Abandonment, and Lost Sources

- a) Notification shall be made to the Department Whenever whenever an incident has occurred as described in 32 Ill. Adm. Code 340.4050 340.1220 or 340.4050 340.1230. has occurred or Notification shall also be made to the Department whenever a source is leaking or contaminated in accordance with 32 Ill. Adm. Code 340.1260 or stolen, missing or lost, other than in downhole logging operations, notification shall be made to the Department in accordance with 32 Ill. Adm. Code 340.4020 340.1210.
- b) Whenever a sealed source or device containing radioactive material is lodged downhole, the licensee or registrant shall:
- 1) monitor Monitor at the surface for the presence of radioactive contamination with a radiation survey instrument or logging tool during logging tool recovery operations; and
 - 2) notify Notify the Department immediately by telephone if radioactive contamination is detected at the surface or if the source appears to be damaged.
- c) When it becomes apparent that efforts to recover the radioactive source will not be successful, the licensee or registrant shall:
- 1) advise Advise the well-operator of the regulations of the Illinois Department of Nuclear Safety regarding abandonment and the method of abandonment, which shall include:
 - A) the The immobilization and sealing in place of the radioactive source with a cement plug;
 - B) the The setting of a whipstock or other deflection device; and
 - C) the The mounting of a permanent identification plaque, at the surface of the well, containing the appropriate information required by Section 351.5010(d) subsection (e) below;
 - 2) notify Notify the Department immediately by telephone, and by mail within ten 10 7 calendar days, giving the circumstances of the loss and requesting approval of the adopted abandonment procedures; and
 - 3) file File a written report with the Department within 30 days of the abandonment, setting forth the following information:
 - A) date Date of occurrence and a brief description of attempts to recover the source;
 - B) a A description of the radioactive source involved, including radionuclide, quantity, and chemical and physical form;
 - C) surface Surface location and identification of well;
 - D) results Results of efforts to immobilize and seal the source in place;
 - E) depth Depth of the radioactive source;
 - F) depth Depth of the top of the cement plug;
 - G) depth Depth of the well; and
 - H) information Information contained on the permanent

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- identification plaque.*
- d) The Department will provide written approval of the request by the licensee pursuant to subsection (c)(2) above if the Department determines that accepted industry methods for recovery have been unsuccessful and the proposed abandonment procedures satisfy the requirements of subsection (c)(1) above.
- e) Whenever a sealed source containing radioactive material is abandoned downhole, the licensee shall provide a permanent plaque* for posting the well or well-bore. This plaque shall:
- *AGENCY NOTE: An example of a suggested plaque is shown in Appendix-B of this Part Section 351. Appendix B.
- 1) be Be constructed of long-lasting material, such as stainless steel or monel; and
 - 2) contain Contain the following information engraved on its face:
 - A) the The word "CAUTION";
 - B) the The radiation symbol without the conventional color requirement;
 - C) the The date of abandonment;
 - D) the The name of the well operator or well owner;
 - E) the The well name and well identification number(s) or other designation;
 - F) the The sealed source(s) by radionuclide and quantity of activity;
 - G) the The source depth and the depth to the top of the plug; and
 - H) an An appropriate warning, depending on the specific circumstances of each abandonment.*
- *AGENCY NOTE: Appropriate warnings may include: "Do not drill below plug back depth"; "Do not enlarge casing"; or "Do not re-enter the hole" followed by the words, "before contacting the Illinois Department of Nuclear Safety".
- f) The licensee or registrant shall notify the Department immediately by telephone and by mail within ten 10 7 calendar days, if the licensee knows or has reason to believe that radioactive material has been lost in or to an underground potable water source. Such notice shall designate the well location and shall describe the magnitude and extent of loss of radioactive material, assess the health and environmental consequences of such loss, and explain efforts planned or being taken to mitigate these consequences.

(Source: Amended at 18 Ill. Reg. _____, effective FEB 22 1994)

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Section 351.APPENDIX B Example of Plaque for Identifying Wells Containing Sealed Sources Containing Radioactive Material Abandoned Downhole



The size of the plaque should be convenient for use on active or inactive wells, e.g., an 18-centimeter (7-inch) square. Letter size of the word "CAUTION" should be approximately twice the letter size of the rest of the information, e.g., 12-millimeter (1/2-inch) and 6-millimeter (1/4-inch) letter size, respectively. Quantities and distances may be expressed either in SI units or in special and English units or in dual units as above.

(Source: Approved 18 111. Reg. effective

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1) Heading of the Part: REGISTRATION OF RADIOACTIVE MATERIAL, RADIATION MACHINES, AND RADIATION INSTALLATIONS

2) Code Citation: 32 Ill. Adm. Code 320

3) Section Number:
320.10
320.15
320.30
320.40
Adopted Action:
Amendment
New Section
Amendment
Amendment

4) Statutory Authority: Implementing and authorized by the Radiation Installation Act (111. Rev. Stat. 1991, ch. 111 1/2, par. 193.9 - 200) [420 ILCS 30].

5) Effective Date of Amendments: FEB 2 2 1994

6) Does this rulemaking contain an automatic repeal date? No

7) Does this amendment contain incorporations by reference? Yes

8) Date filed in Agency's Principal Office: February 17, 1994

9) Notice of Proposal Published in the Illinois Register:

June 18, 1993 (17 Ill. Reg. 8693)

10) Has JCAR issued a Statement of Objections to these Amendments? No

11) Differences between proposal and final version:

a) In the Table of Content, by inserting "320.15 Incorporations by Reference".

b) In the Authority Note, on line 3, by changing "[420 ILCS 30/0.01 - 30/8]" to "[420 ILCS 30]".

c) In Section 320.10:

in subsection (a)(1), on line 3, by deleting the comma after the word "used";

in subsections (a)(1)(A) and (B), by changing the comma to a semi-colon at the end of the subsections;

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in subsection (a)(1)(C), on line 1, by deleting the comma after the word "strength"; and on line 3, by deleting the comma after the word "stored";

in subsection (a)(2)(A), (B), (C), (D) and (E), by changing the comma to a semi-colon at the end of the subsections.

d) By inserting a new Section as follows:

"Section 320.15 Incorporations by Reference

All rules, standards and guidelines of agencies of the United States or nationally recognized organizations or associations that are incorporated by reference in this Part are incorporated as of the date specified in the reference and do not include any later amendments or editions. Copies of these rules, standards and guidelines that have been incorporated by reference are available for public inspection at the Department of Nuclear Safety, 1035 Outer Park Drive, Springfield, Illinois. Copies of the standards established by the National Council on Radiation Protection and Measurements (NCRP) can be obtained directly from NCRP Publications, 7910 Woodmont Avenue, Suite 800, Bethesda, MD 20814."

e) In Section 320.30, on line 2, by deleting the comma after the word "using".

f) In Section 320.40:

in the lead in paragraph, on line 2, by deleting "30/" and on line 8, by deleting the comma after the word "machines";

in subsection (a), on line 8, by deleting "40/"; and in the Agency Note, by deleting the last two sentences;

in subsection (b), on line 3, by deleting "40/"; and by inserting and deleting the old table; and by adding a new table;

in subsection (c), on line 3, by deleting "40/";

in subsection (d), on line 11, by deleting "40/"; and in the Agency Note, by deleting the last two sentences;

in subsection (e), on line 10, by deleting "40/"; and in the agency note, by deleting the last two sentences;

in subsection (f), on line 4, by deleting "40/";

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in subsection (g), on line 5, by deleting "40/"; and in the Agency Note, by deleting the last two sentences.

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? The Joint Committee on Administrative Rules did not issue an agreement letter for this Part.

13) Will these amendments replace an emergency amendment currently in effect? No

14) Are there any amendments pending on this Part? No

15) Summary and Purpose of Amendments: The Amendment will: (a) change cross references to new Part 340; (2) insert dual (metric and English/special) units of measure; (c) make stylistic changes so that the rules look consistent from Part to Part; and (d) change statutory citations to the ILCS. In addition, this Amendment will add a new Section 320.15, "Incorporations by Reference" which sets forth general information regarding rules, standards and guidelines that are incorporated into Part 320 by reference.

16) Information and questions regarding these amendments shall be directed to:

Valerie Puccini
Staff Attorney
Department of Nuclear Safety
1035 Outer Park Drive
Springfield, Illinois 62704
(217) 785-9881 (voice)
(217) 785-9900 (TDD)

The full text of the Adopted Amendments begins on the next page:

Chicago Kent City School District

- Section
320.10 Registration
320.15 Incorporations by Reference
320.20 Amendments
320.30 Discontinued Use
320.40 Exemptions
320.50 Noncompliance

AUTHORITY: Implementing and authorized by the Radiation Installation Act (Ill. Rev. Stat. 1991, ch. 111 1/2, pars. 193.9 - 200) [420 ILCS 30].

SOURCE: Filed April 20, 1974 by the Department of Public Health; transferred to the Department of Nuclear Safety by P.A. 81-1516, effective December 3, 1980; codified at 7 Ill. Reg. 11278; amended at 10 Ill. Reg. 17529, effective September 25, 1986; amended at 14 Ill. Reg. 13644, effective August 13, 1990; amended at 18 Ill. Reg. _____, effective FEB 2 2 1994.

Section 320.10 Registration

- a) Installation Registration
- 1) Any operator of a facility where radiation machines are used or where radioactive material is produced, transported, stored, used, or disposed of for any purpose, which is not subject to regulation by the U.S. Nuclear Regulatory Commission (NRC), shall register such radiation installation with the Department of Nuclear Safety (Department). The operator shall register the installation before the installation is placed in operation on a form prescribed by the Department which shall include:
- A) the operator's name;
B) the location and confines of the radiation installation;
C) the type, strength and number of sources of radiation expected to be produced, used, operated, stored or disposed.
- 2) When the number of sources exceeds 50, the Director will, upon request of the operator, permit blanket registration of the installation. This blanket registration shall be on a form prescribed by the Department and shall include:
- A) the operator's name;
B) the location and confines of the radiation installation;

- C) a description of each type and range of strengths of each type of source of radiation;
D) the number of each type of source;
E) the radionuclide in each type of source; and
F) the specific information requested on form IL 473-0013 regarding registration of x-ray machines.
- b) Machine Registration
- 1) Every operator of a radiation installation where radiation machines are located shall register such machines with the Department.
- 2) Installation operators shall register radiation machines annually on a form prescribed by the Department. The registration form shall be filed before February 1 of each year. An annual registration fee of \$10.00 per radiation machine for each machine possessed on January 1 of each year shall be submitted with the registration form.

(Source: Amended at 18 Ill. Reg. _____, effective FEB 2 2 1994)

Section 320.15 Incorporations by Reference

All rules, standards and guidelines of agencies of the United States or nationally recognized organizations or associations that are incorporated by reference in this part are incorporated as of the date specified in the reference and do not include any later amendments or editions. Copies of these rules, standards and guidelines that have been incorporated by reference are available for public inspection at the Department of Nuclear Safety, 1035 Outer Park Drive, Springfield, Illinois. Copies of the standards established by the National Council on Radiation Protection and Measurements (NCRP) can be obtained directly from NCRP Publication, 7910 Woodmont Avenue, Suite 800, Bethesda MD 20814.

(Source: Added at 18 Ill. Reg. _____, effective FEB 2 2 1994)

Section 320.30 Discontinued Use

If any operator discontinues using radiation machines or producing, transporting, storing, using or disposing of radioactive material, the operator shall notify the Department within thirty 30 days after such discontinuance. The notification shall include the date of discontinuance and the disposition of such radiation machines or radioactive material.

(Source: Amended at 18 Ill. Reg. _____, effective FEB 2 2 1994)

Section 320.40 Exemptions

C(14)	37,000	1,000	Na(24)	37,000	1,000
S(35)	37,000	1,000	K(42)	37,000	1,000
Ce(51)	37,000	1,000	Fe(55)	37,000	1,000
Mn(56)	37,000	1,000	Ni(59)	37,000	1,000
Cu(64)	37,000	1,000	Ge(71)	37,000	1,000
Mg(99)	37,000	1,000	Pd(103)	37,000	1,000
Pm(147)	37,000	1,000	Ir(190)	37,000	1,000
Au(196)	37,000	1,000	Tl(201)	37,000	1,000
Tl(202)	37,000	1,000	Natural U	37,000	1,000
Natural Th	37,000	1,000			

c) Radioactive materials in sealed sources in total quantities not exceeding 37 MBq (one millicurie) for a given installation. (See Section 3(c).)

d) Timepieces, instruments, novelties, or devices containing self-luminous elements, except during the manufacture of the self-luminous elements, and the production of said timepieces, instruments, novelties and except when the timepieces, instruments, novelties, or devices are stored, used, repaired, handled, or disposed in such quantity or fashion that any person might receive within a week a radiation dose exceeding one-tenth the maximum permissible total weekly dose for any critical organ exposed, as determined by the standards established by the National Committee on Radiation Protection. (See Section 3(d).)

AGENCY NOTE: The name of the National Committee on Radiation Protection has been changed to the National Council on Radiation Protection and Measurements. Copies of the standards established by the National Committee on Radiation Protection are available for public inspection at the Department. Copies of standards can also be obtained directly from the National Committee of Radiation Protection Publications, 7910 Woodmont Avenue, Suite 1016 Bethesda, MD 20814.

e) Electrical equipment that is manufactured for purposes other than generation of radiation, where the generation of radiation is incidental to operation (such as a television), and that operates in such a manner that no person may receive within a week a radiation dose exceeding one-tenth the maximum permissible total weekly dose for any critical organ exposed. Determinations of doses shall be made in accordance with the standards established by the National Committee of Radiation Protection. The production testing or production servicing of all such electrical equipment shall not be exempt from registration. (See Section 3(e).)

AGENCY NOTE: The name of the National Committee on Radiation Protection has been changed to the National Council on Radiation Protection and Measurements. Copies of the standards established by the National Committee on Radiation Protection are available for public inspection at the Department. Copies of standards can also be obtained directly from the National Committee of Radiation Protection Publications, 7910 Woodmont Avenue, Suite 1016 Bethesda, MD 20814.

f) Any radioactive material or radiation machine being transported on vessels, aircraft, railroad cars, or motor vehicles in conformity

with regulations adopted by any agency having jurisdiction over safety during transportation. (See Section 3(f).)

g) Radiation machines, radioactive materials, and radiation installations which the Department of Nuclear Safety finds to be without radiation hazard, as determined by the standards established by the National Committee on Radiation Protection. (See Section 3(g).)

AGENCY NOTE: The name of the National Committee on Radiation Protection has been changed to the National Council on Radiation Protection and Measurements. Copies of the standards established by the National Committee on Radiation Protection are available for public inspection at the Department. Copies of standards can also be obtained directly from the National Committee of Radiation Protection Publications, 7910 Woodmont Avenue, Suite 1016 Bethesda, MD 20814.

(Source: Amended at 18 Ill. Reg. _____, effective _____)

FEB 22 1994

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

- 1) Heading of the Part: Demonstration Programs
- 2) Code Citation: 89 Ill. Adm. Code 170
- 3) Section Numbers:

170.50	Amendment
170.250	New Section
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1991, ch. 23, pars. 4-1.6a new and 12-13) [305 ILCS 5/Art. 4-1.6a new and 5/12-13]
- 5) Effective Date of Amendments: February 28, 1994
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Do these Amendments contain incorporations by reference? No
- 8) Date Filed in Agency's Principal Office: February 28, 1994
- 9) Notice of Proposal Published in Illinois Register:
November 12, 1993 (17 Ill. Reg. 19440)
- 10) Has JCAR issued a Statement of Objections to these Adopted Amendments? No
- 11) Differences between proposal and final version: No changes were made to the text of this rulemaking.
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes
- 13) Will these Amendments replace Emergency Amendments currently in effect?
Yes
- 14) Are there any Amendments pending on this Part? No
- 15) Summary and Purpose of Amendments: These proposed amendments will enable the Department to implement the Work Pays Project. The Work Pays Project will simplify the system of budgeting earned income within the Aid to Families with Dependent Children program so that it provides AFDC clients with an easily understood financial incentive to seek and maintain employment and leave welfare. The project's primary objective is to substantially increase the percentage of AFDC clients who are working.

As a result of these proposed amendments, the Department will implement a new earned income calculation system that allows employed clients to

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- retain more of their grants while they transition to self-sufficiency. The new earned income disregards will create a financial incentive for clients to work and supplement their AFDC benefits. Within this new project, it will be financially more advantageous for clients to obtain employment, stay employed and progressively increase their average hours worked per week and wage per hour. The incentive will allow them to achieve a family income higher than the federal poverty level and make them no longer eligible for cash benefits. The entire project will reward clients who work and give them a greater opportunity to become self-sufficient through their jobs.
- The simplified system will make it much easier for IDPA workers to explain to clients the impact that employment earnings will have on their grants. The simpler/improved explanations will reduce clients' concerns about whether they can go to work and keep a reasonable level of grant income while adjusting to employment. Clients will be able to understand how the Department's new earned income system applies to them. They will be able to accurately predict how and when their grants will change when their earnings increase. In addition, they will be able to understand the impact on their eligibility for Medicaid and supportive services, such as child care, without having to be concerned with complex time limits. The Department is requesting waivers needed to implement and test the Work Pays Project.
- The Work Pays Demonstration Project is designed to make working more profitable than staying on welfare. Employed clients will have 2/3 of their gross earned income disregarded. Only 1/3 of their gross earnings will be budgeted. Under these proposed amendments, public aid recipients will be able to keep \$2 out of every \$3 earned until the family is no longer eligible for a grant.
- The proposed procedure is very simple. For every \$3 an individual earns, the grant will be reduced by \$1 until the family is no longer eligible for a grant. This procedure will be easy for staff to implement, but more importantly, it will be easy for staff to explain to clients. Clients will be able to calculate their benefits and understand the financial benefits of working. The \$2 for \$3 budget initiative allows clients to go to work and keep a reasonable level of grant income while adjusting to employment. It enables them to predict accurately how and when their grants will change as earnings increase and, most importantly, plan for the future.
- This new budgeting policy applies statewide except for Champaign and Lake Counties. In these target counties, cases will be assigned to the control group, experimental group or to neither. The control group cases will continue to be budgeted using the former earned income disregards (i.e. \$90 employment expense and \$30 and 1/3 earned income exemption). The experimental groups cases and those not assigned to either group will be budgeted using the new 2/3 disregard.

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Under the previous system, incentives to work dropped sharply after four months and disappeared entirely after 12 months. Under these new amendments, cash assistance grants will not automatically change after the fourth month, but will be determined by a client's monthly income until that income reaches the poverty level.

In addition, these proposed amendments exclude Champaign County from the Departments Income Budgeting Demonstration Project. Rock Island County is currently the only county excluded from the Income Budgeting Demonstration Project. The Income Budgeting Demonstration Project is designed to increase the motivation of clients to find work by eliminating the negative effects of retrospective budgeting. To measure the effectiveness of the Fresh Start Welfare Reform Demonstration, these proposed amendments establish that the Income Budgeting Demonstration Project will be statewide except for both Rock Island and Champaign Counties.

16) Information and questions regarding these Adopted Amendments shall be directed to:

Name: Judy Umunna
Address: Bureau of Rules and Regulations
Illinois Department of Public Aid
100 South Grand Avenue East, Third Floor
Springfield, Illinois 62762
Telephone: (217) 524-3215

The full text of the Adopted Amendments begins on the next page:

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TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER g: DEMONSTRATION PROGRAMS

PART 170
DEMONSTRATION PROGRAMS

SUBPART A: THE FRESH START WELFARE REFORM DEMONSTRATION PROGRAM

Section	
170.10	Youth Employment and Training Initiative
170.20	Paternal Involvement Project
170.30	Homeless Families Support Project
170.40	Family Responsibility Project
170.50	Income Budgeting Project

SUBPART B: THE CAREER ADVANCE PROGRAM

Section	
170.100	The Career Advancement Program
170.110	Career Advancement Experimental and Control Groups
170.120	Career Advancement Participation Requirements of Experimental Group Members
170.130	Career Advancement Supportive Services for Experimental Group Members

SUBPART C: COMMUNITY GROUP PARTICIPATION PROGRAM

Section	
170.200	Community Group Participation Program

SUBPART D: EARNED INCOME INITIATIVE

170.250	Work Pays Demonstration
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AUTHORITY: Implementing and authorized by Sections 11-20, 12-13 and 12-4.28 of the Illinois Public Aid Code (Ill. Rev. Stat. 1991, ch. 23, pars. 11-20, 12-13 and 12-4.28) [305 ILCS 5/ALts. 11-20, 12-13 and 12-4.28]

SOURCE: Adopted at 13 Ill. Reg. 14067, effective August 23, 1989; amended at 14 Ill. Reg. 19320, effective November 30, 1990; amended at 17 Ill. Reg. 19197, effective October 25, 1993; emergency amendment at 17 Ill. Reg. 19721, effective November 1, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. _____, effective February 28, 1994.

NOTE: CAPITALIZATION DENOTES STATUTORY LANGUAGE.

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SUBPART A: THE FRESH START WELFARE REFORM DEMONSTRATION PROGRAM

Section 170.50 Income Budgeting Project

a) The Income Budgeting Project is a four year demonstration program of experimental design operated by the Department. The purpose of the project is to demonstrate that a combination of prospective and retrospective budgeting of earned income encourages AFDC recipients to accept employment.

b) Elements of the Income Budgeting Project

- 1) When a recipient reports that he has begun employment and a determination has been made that he remains eligible for AFDC, the earned income shall be budgeted prospectively for the first two months.
- 2) After the first two months, the income shall be budgeted retrospectively.
- 3) An adjustment for under or overpayments which occurred during the first two months of prospective budgeting shall be made.
- 4) If a recipient reports and verifies that employment has ended, budgeting of earnings shall end with the first month of non-employment.

c) Selection Criteria

Participants in The Income Budgeting Project are:

- 1) All AFDC recipients who have earned income and who do not reside in Rock Island County or Champaign County;
- 2) In Rock Island County, those AFDC clients randomly selected by the Department for participation.

d) Experimental and Control Groups

- 1) Individuals will be assigned to one of the following groups:

- A) an experimental group which shall consist of those individuals who will be entitled to the elements of the Income Budgeting Project; or
- B) a control group in Rock Island County which shall consist of those individuals who meet the criteria of subsection

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Section 170.50(d)(1)(B) (continued)

(c)(2) above, but will have earned income budgeted under the Department's current budgeting method.

- 2) As long as the Income Budgeting Project is in effect, a case designated as an experimental or control group member retains that designation for purposes of data collection even if that case leaves the project area or stops receiving AFDC.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

SUBPART D: EARNED INCOME INITIATIVE

Section 170.250 Work Pays Demonstration

a) The Work Pays is a four year demonstration program of experimental design to be operated by the Department upon receipt of necessary federal waivers. Goals of this demonstration are to simplify the budgeting of earned income and to provide AFDC clients with a greater financial incentive to work and become self supporting.

b) All AFDC applicants and recipients are included in this demonstration except for those in Champaign and Lake Counties. In those locations, participants will be randomly selected for participation. All AFDC applicants and recipients and those who are assigned to the experimental group in Champaign and Lake Counties will have eligibility and the level of assistance determined by budgeting earned income in accordance with this Section. Those cases in Champaign and Lake Counties assigned to the control group will have eligibility and the level of assistance determined by budgeting earned income in accordance with 89 Ill. Adm. Code 112. Subpart G, as specified for the control group. Participants in the Homeless Families Support Project (see Section 170.30) are excluded from this demonstration.

c) At the time of application for AFDC, each employed applicant will be allowed a \$90.00 deduction from earned income. The remainder plus all other budgetable income will be compared to the payment level to determine eligibility.

d) For employed recipients, all available income will be compared to the federal poverty level to determine continued eligibility. If eligible, one-third of each individual's earnings and all other budgetable income will be deducted from the family's payment level.

(Source: Added at 18 Ill. Reg. _____, effective February 28, 1994)

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1) Heading of the Part: Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)

2) Code Citation: 89 Ill. Adm. Code 149

3) Section Numbers: Adopted Action:

149.5, 149.10, 149.25 Amendment
149.50, 149.75, 149.100 Amendment
149.105, 149.125, 149.140 Amendment
149.150 Amendment

4) Statutory Authority: Articles III, IV, V, VI, VII and Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1991, ch. 23, pars. 3-1 et seq., 4-1 et seq., 5-1 et seq., 6-1 et seq., 7-1 et seq., and 12-13) [305 ILCS 5/Arts. 3, 4, 5, 6, 7 and 5/12-13] and Public Act 88-88, effective July 14, 1993.

5) Effective Date of Amendments: February 25, 1994

6) Does this rulemaking contain an automatic repeal date? No

7) Do these Amendments contain incorporations by reference? No

8) Date Filed in Agency's Principal Office: February 25, 1994

9) Notice of Proposal Published in Illinois Register:

September 24, 1993 (17 Ill. Reg. 15243)

10) Has JCAR issued a Statement of Objections to these Adopted Amendments? No

11) Differences between proposal and final version: The following changes have been made in the proposed amendments.

Section 149.50

Subsection (c)(8) has been changed to read:

County-Owned Hospitals and Hospitals Organized Under the University of Illinois Hospital Act. County-owned hospitals located in an Illinois county with a population greater than three million and hospitals organized under the University of Illinois Hospital Act are excluded from the DRG system and are reimbursed under unique hospital-specific reimbursement methodologies as described in 89 Ill. Adm. Code 148.160 and 149.170.

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Section 149.100

Subsection 149.100(c)(1) has been revised by being underlined in its entirety, as new language.

Section 149.105

In subsection (a)(2)(A) reference to "Section 149.100(b)(2)(C)" has been changed to read "149.100(c)(1)".

In subsection (e) insert "excluding payments described in 89 Ill. Adm. Code 148.120" after the word "Department".

Section 149.125

In subsection (b)(2)(C) reference to "subsection (b)(2)" has been changed to read "subsection (b)".

Section 149.140

Subsection (b)(5)(A) has been revised to read:

5) "Major academic hospital" means:

A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), a hospital located in the State of Illinois, with at least 350 acute care, inpatient beds and at least 130 full-time equivalent residents. The source of this information will be the most recent available American Hospital Association Guide.

In subsection (b)(8)(A)(iii), delete the word "a" before "5,000".

In subsection (b)(10), "Authority" has been changed to "Administration".

Section 149.150

Subsections (c)(1)(B)(i) and (ii) have been revised by being underlined as new language. In subsection (c)(1)(B)(ii), the words "(c)(1)(B) or subsection (c)(1)(C)" in the last two lines have been removed.

Subsection (c)(6) has been deleted in its entirety, and subsection (c)(7) has been renumbered to subsection (c)(6).

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes

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13) Will these Amendments replace Emergency Amendments currently in effect?
Yes

14) Are there any Amendments pending on this Part? No

15) Summary and Purpose of Amendments: These amendments provide for extensive changes in the Department's rules governing payment under the Diagnosis Related Grouping (DRG) Prospective Payment System (PPS) (89 Ill. Adm. Code 149). The rules specify a methodology for the payment of hospitals, which is an alternative to the methodologies included in the Department's hospital services rules (89 Ill. Adm. Code 148). Corresponding rules were effective on October 1, 1993, through emergency rulemaking which was published on October 8, 1993 at 17 Ill. Reg. 17275. These amendments are required to update the rules for implementation of the revised reimbursement procedures which took effect on October 1, 1993, under Public Act 88-88.

The substantive changes are as follows:

- Effective October 1, 1993, inpatient hospital reimbursement for hospitals reimbursed under the Diagnosis Related Grouping (DRG) Prospective Payment System (PPS) (89 Ill. Adm. Code 149) will be maintained at the rate in effect on June 30, 1993, with certain exceptions. Effective on and after April 1, 1994, inpatient hospital reimbursement rates for hospitals reimbursed under the above Part will be recalculated in accordance with the new provisions contained in these proposed amendments.
- Many of the changes reflect additions to, or clarification of, definitions utilized by the Department with respect to hospital reimbursement.
- Many of the changes clarify current reimbursement policies.
- Section 149.100 (Basic Methodology for Determining DRG Prospective Payment Rates) has been revised to reflect a change in the rate period. The rate period beginning on October 1, 1992, has been extended through March 31, 1994. Effective with rate periods beginning on or after April 1, 1994, a number of changes will take place in the reimbursement methodology as follows:
 - Reimbursement rates will be calculated on April 1, 1994, using the methodologies described in this proposed amendment. Rate periods will begin 90 days after the effective date of DRG PPS rates under the federal Medicare Program and will end 90 days after any subsequent DRG PPS rate change under the federal Medicare Program.

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- Hospitals deemed as rural hospitals as of July 14, 1993, that were not previously deemed as rural hospitals at the beginning of the rate period (October 1, 1992) and are designated as sole community hospitals under the methodology described in this proposed amendment, and that elect to be reimbursed under the Diagnosis Related Grouping (DRG) Prospective Payment System (PPS) (89 Ill. Adm. Code Part 149), will be reimbursed in accordance with the methodologies described in these proposed amendments.
- Section 149.105 (Payment for Outlier Cases) has been revised to reflect a change in the rate period beginning on October 1, 1992, which has been extended through March 31, 1994. Effective with rate periods beginning on or after April 1, 1994, outlier payment adjustments will be calculated on April 1, 1994, using the methodologies described in these proposed amendments. Rate periods will begin 90 days after the effective date of DRG PPS rates under the federal Medicare Program and will end 90 days after any subsequent DRG PPS rate change under the federal Medicare Program.
- Section 149.125 (Special Treatment of Certain Facilities) has been revised to reflect a change in the criteria for qualification as a sole community hospital as described in these proposed amendments.
- Section 149.125 has also been revised to reflect a change in the rate period, and the rate period beginning on October 1, 1992, has been extended through March 31, 1994. Effective with rate periods beginning on or after April 1, 1994, sole community hospital designation will be determined on April 1, 1994, using the methodology described in this proposed amendment. Rate periods will begin 90 days after the effective date of DRG PPS rates under the federal Medicare Program and will end 90 days after any subsequent DRG PPS rate change under the federal Medicare Program.
- Section 149.140 (Methodology for Determining Primary Care Access Health Care Education Payments) contains extensive revisions. These revisions:
 - Reflect a change in the rate periods as described in these proposed amendments.
 - Amend the criteria for qualification for, and the payment methodology for calculation of, the primary care access health care education payments.
 - Require that qualified hospitals provide documentation of actual rotation time spent in qualified rotation settings as well as verification that certain facilities meet the proposed

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requirements of a qualified rotation setting, provide the names and program year of individual residents, and provide data maintained for residency review committees.

- Establish a ceiling on the aggregate payments that may be made with respect to the Primary Care Access Health Care Education Program.
- Establish an appeals process allowing hospitals the opportunity to request and receive a review of the payment and adjustment amounts calculated by the Department under the provisions of this proposed amendment.

Section 149.150 (Payments to Hospitals Under the DRG Prospective Payment System) has been revised to reflect a change in the rate period. The rate period beginning on October 1, 1992, has been extended through March 31, 1994. Effective with rate periods beginning on or after April 1, 1994, a number of changes will take place in the reimbursement methodology as follows:

- Reimbursement rates will be calculated on April 1, 1994, using the methodologies described in this proposed amendment. Rate periods will begin 90 days after the effective date of DRG PPS rates under the federal Medicare Program and will end 90 days after any subsequent DRG PPS rate change under the federal Medicare Program.
- For rate periods beginning on or after April 1, 1994, payments for capital, direct medical education, indirect medical education, and Certified Registered Nurse Anesthetist (CRNA) costs will be made on a per diem, rather than a per case, basis.
- For the calculation of direct medical education costs, hospitals will be separated into two peer groups, major teaching hospitals and other teaching hospitals. The adjusted direct medical education cost per diem for all hospitals in each peer group will be calculated by utilizing the direct medical education cost per diems that were in effect on June 30, 1993. The adjusted direct medical education cost per diem will be rank ordered for all hospitals reporting such costs within each peer group, and capped at the 80th percentile. Hospitals will receive a per diem add-on for direct medical education costs in accordance with the methodology described in this proposed amendment.

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16) Information and questions regarding these Adopted Amendments shall be directed to:

Name: Joanne Jones
Address: Bureau of Rules and Regulations
Illinois Department of Public Aid
100 South Grand Avenue East, Third Floor
Springfield, Illinois 62762
Telephone: (217) 524-3215

The full text of the Adopted Amendments begins on the next page:

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TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER d: MEDICAL PROGRAMS

PART 149

DIAGNOSIS RELATED GROUPING (DRG)
PROSPECTIVE PAYMENT SYSTEM (PPS)

Section	Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)
149.5	Applicability of Other Provisions
149.10	General Provisions
149.25	Hospital Services Subject to and Excluded from the DRG Prospective Payment System
149.50	Conditions for Payment Under the DRG Prospective Payment System
149.75	Basic Methodology for Determining DRG Prospective Payment Rates
149.100	Payment For Outlier Cases
149.105	Special Treatment of Certain Facilities
149.125	Methodology for Determining Primary Care Access Health Care Education Payments
149.140	Payments to Hospitals Under the DRG Prospective Payment System
149.150	Payments to Contracting Hospitals (Repealed)
149.175	Admitting and Clinical Privileges (Repealed)
149.200	Inpatient Hospital Care or Services by Non-Contracting Hospitals
149.205	Eligible for Payment (Repealed)
149.225	Payment to Hospitals for Inpatient Services or Care not Provided under the ICARE Program (Repealed)
149.250	Contract Monitoring (Repealed)
149.275	Transfer of Recipients (Repealed)
149.300	Validity of Contracts (Repealed)
149.305	Termination of ICARE Contracts (Repealed)
149.325	Hospital Services Procurement Advisory Board (Repealed)

AUTHORITY: Implementing Article II of the Illinois Health Finance Reform Act (Ill. Rev. Stat. 1991, ch. 111 1/2, par. 6503-1 et seq.) [20 ILCS 2215/Art. 3] and implementing and authorized by Articles III, IV, V, VI, VII and Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1991, ch. 23, pars. 3-1 et seq., 4-1 et seq., 5-1 et seq., 6-1 et seq., 7-1 et seq., and 12-13) [305 ILCS 5/Arts. 3, 4, 5, 6, 7, and 5/12-13].

SOURCE: Recodified from 89 Ill. Adm. Code 140.940 thru 140.972 at 12 Ill. Reg. 7401; amended at 12 Ill. Reg. 12095, effective July 15, 1988; amended at 13 Ill. Reg. 554, effective January 1, 1989; amended at 13 Ill. Reg. 15070, effective September 15, 1989; amended at 15 Ill. Reg. 1826, effective January 28, 1991; emergency amendment at 15 Ill. Reg. 16308, effective November 1, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 6195, effective March 27, 1992; emergency amendment at 16 Ill. Reg. 11937, effective July 10, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14733,

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effective October 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19868, effective December 7, 1992; amended at 17 Ill. Reg. 3217, effective March 1, 1993; emergency amendment at 17 Ill. Reg. 17275, effective October 1, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. _____, effective February 25, 1994.

NOTE: CAPITALIZATION DENOTES STATUTORY LANGUAGE.

Section 149.5	Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)
a)	Sections 149.25 through 149.150 describe:
a)1)	The basis of payment for inpatient hospital services under the DRG PPS and sets set forth the general basis for the system;
b)2)	Classifications of hospitals that are included and excluded from the DRG PPS and the requirements governing inclusion or exclusion of hospitals in the system as a result of changes in their classification;
e)3)	Conditions that must be met for a hospital to receive payment under the DRG PPS;
d)4)	The methodology by which DRG prospective rates are determined;
e)5)	The methodology for determining additional payments for outlier cases;
f)6)	The rules for special treatment of certain facilities; and
g)7)	The types, amounts and methods of payment to hospitals under the DRG PPS.
h)8)	Notwithstanding any other provisions of this Part, reimbursement to hospitals for services provided July 1, 1992 through September 30, 1992, October 1, 1992, through March 31, 1994, shall be as follows:
1)	Base Inpatient Payment Rate. For inpatient hospital services rendered, or, if applicable, for inpatient hospital admissions occurring, on and after July 1, 1992, October 1, 1992, and on or before September 30, 1992, March 31, 1994, the Department shall reimburse hospitals for inpatient services under the reimbursement methodologies in effect for each hospital, and at the base inpatient payment rate calculated for each hospital, as of June 30, 1992 June 30, 1993. The term "base inpatient

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Section 149.5(b)(1) (continued)

Section 149.5(c) (continued)

payment rate" shall include the reimbursement rates calculated effective October 1, 1992, under Part 149.

2) Exceptions. The provisions of subsection (b)(1) above shall not apply to:

- A) Hospitals reimbursed under 89 Ill. Adm. Code 148.82, 148.160, or 148.170. Reimbursement for such hospitals shall be in accordance with 89 Ill. Adm. Code 148.82, 148.160, or 148.170, as applicable.
- B) Hospitals reclassified as rural hospitals as described in 89 Ill. Adm. Code 148.40(f)(4). Reimbursement for such hospitals shall be in accordance with 89 Ill. Adm. Code 148.40(f)(4) and 148.260, or Section 149.100(c)(1)(A), whichever is applicable.
- C) The inpatient payment adjustments described in 89 Ill. Adm. Code 148.120, 148.150, and 148.290. Reimbursement for such inpatient payment adjustments shall be in accordance with 89 Ill. Adm. Code 148.120, 148.150, and 148.290, and shall be in addition to the base inpatient payment rate described in subsection (b)(1) above.

2) For the purpose of calculating the inpatient payment rate for each hospital eligible to receive quarterly payment adjustments for uncompensated care, as defined by the Department on June 30, 1992, the payment adjustment for the period August 1, 1992 through September 30, 1992, shall be one-sixth of the total uncompensated care payment adjustment calculated for each eligible hospital for the uncompensated care rate year, as defined by the Department, ending on July 31, 1992.

2) For the purpose of calculating the inpatient payment rate for each hospital eligible to receive quarterly payment adjustments for uncompensated care, as defined by the Department on June 30, 1992, the payment adjustment for the period August 1, 1992 through September 30, 1992, shall be one-sixth of the total uncompensated care payment adjustment calculated for each eligible hospital for the uncompensated care rate year, as defined by the Department, ending on July 31, 1992.

c) Definitions

Unless specifically stated otherwise, the definitions of terms used in this Part are as follows:

1) "DRG grouper" means:

- A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the HCFA Medicare DRG grouper in effect on September 1, 1992, adjusted for differences in Medicare and Medicaid policies and populations, as described in Section 149.100(a)(1).
- B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the HCFA Medicare DRG grouper which is in effect 90 days prior to the date of admission, adjusted for differences in Medicare and Medicaid policies and populations, as described in Section 149.100(a)(1).

2) "Medicare weighting factor" means:

- A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the Medicare DRG weighting factors in effect on September 1, 1992, adjusted for differences in Medicare and Medicaid policies and populations, as described in Section 149.100(a)(2).
- B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Medicare DRG weighting factors in effect 90 days prior to the date of admission, adjusted for differences in Medicare and Medicaid policies and populations, as described in Section 149.100(a)(2).

3) "PPS Pricer" means:

- A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the HCFA Medicare PPS Pricer, Version 92.0.
- B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the HCFA Medicare PPS Pricer, version that is in effect 90 days prior to the date of admission.

(Source: Amended at 18 Ill. Reg. _____, effective February 25, 1994)

Section 149.10 Applicability of Other Provisions

The following provisions, in addition to those provisions specifically cited in this Part, shall apply to hospitals reimbursed under the DRG FFS:

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Section 149.10 (continued)

- a) Participation, as described in 89 Ill. Adm. Code 148.20.
- b) Definitions and Applicability, as described in 89 Ill. Adm. Code 148.25.
- b)c) General requirements, as described in 89 Ill. Adm. Code 148.30.
- e)d) Special requirements, as described in 89 Ill. Adm. Code 148.40.
- e)e) Covered hospital services, as described in 89 Ill. Adm. Code 148.50.
- e)f) Services not covered as hospital services, as described in 89 Ill. Adm. Code 148.60.
- f)g) Limitations on hospital services, as described in 89 Ill. Adm. Code 148.70.
- g)h) Hospital outpatient and hospital-based clinic services, as described in 89 Ill. Adm. Code 148.140.
- h)i) Payment for pre-operative days, patient specific orders, and services which can be performed in an outpatient setting, as described in 89 Ill. Adm. Code 148.180.
- i)j) Copayments, as described in 89 Ill. Adm. Code 148.190.
- j)k) Filing cost reports, as described in 89 Ill. Adm. Code 148.210.
- k)l) Review procedure, as described in 89 Ill. Adm. Code 148.310.

(Source: Amended at 18 Ill. Reg. _____, effective February 25, 1994)

Section 149.25 General Provisions

a) Basis of Payment

1) Payment on a Per Discharge Basis

- A) Under the DRG PPS, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to persons receiving coverage under the Medicaid Program.
- B) The DRG prospective payment rate for each discharge (as defined in subsection (b) below) is determined according to

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Section 149.25(a)(2)(B) (continued)

- the methodology described in Sections 149.100 and 149.150, as appropriate. An additional payment is made, in accordance with Sections 149.105, 149.125 and 149.140, as appropriate. The rates paid shall be those in effect on the date of admission.
- 2) Payment in Full
 - (A) The DRG prospective payment amount paid for inpatient hospital services is the total Medicaid payment for the inpatient operating costs (as described in subsection (a)(3) below) incurred in furnishing services covered under the Medicaid Program.
 - B) Except as provided for in subsection (b) below, the full DRG prospective payment amount, as determined under Sections 149.100 and 149.150, as appropriate, is made for each stay during which there is at least one Medicaid eligible day of care.
 - 3) Inpatient Operating Costs. The DRG PPS provides a payment amount for inpatient operating costs, including:
 - A) Operating costs for routine services (as described in 42 CFR 413.53(b), revised as of September 1, 1990), such as the costs of room, board, and routine nursing services;
 - B) Operating costs for ancillary services, such as radiology and laboratory services furnished to hospital inpatients;
 - C) Special care unit operating costs (intensive care type unit services as described in 42 CFR 413.53(b), revised as of September 1, 1990); and
 - D) Malpractice insurance costs related to services furnished to inpatients.
 - E) Hospital-based physician costs as described in Section 149.75(h)(1)(A).
 - 4) Excluded Costs/Services. The following inpatient hospital costs are excluded from the DRG prospective payment amounts:
 - A) Transplant Transplantation costs, including acquisition costs incurred by approved transplantation centers as described in 89 Ill. Adm. Code 148.80 148.82. Kidney and

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Section 149.25(a)(4)(A) (continued)

cornea transplant costs shall be reimbursed under the appropriate methodology described in Sections 149.100 and 149.150 or in 89 Ill. Adm. Code 148.160, 148.170 or 148.250 through 148.300. Kidney acquisition costs shall be reimbursed in accordance with Section 149.150(c)(5).

B) Costs of psychiatric services incurred by a provider enrolled with the Department to provide those services (category of service 21). Such services shall be reimbursed under 89 Ill. Adm. Code 148.270(b).

C) Costs of nonemergency psychiatric services incurred by a provider that is not enrolled with the Department to provide those services (category of service 21). Such services shall not be eligible for reimbursement.

D) Costs of emergency psychiatric services exceeding the maximum of three days emergency treatment incurred by a provider that is not enrolled with the Department to provide those services (DRGs 424-432). Such services exceeding the maximum of 3 three days shall not be eligible for reimbursement.

E) Costs of physical rehabilitation services incurred by a provider enrolled with the Department to provide those services (category of service 22). Such services shall be reimbursed under 89 Ill. Adm. Code 148.270(b).

F) Costs of rehabilitation for drug and alcohol abuse (DRG 436 and that part of DRG 437 apportioned to rehabilitation). Such services shall be reimbursed under 89 Ill. Adm. Code 148.340 through 148.390.

5) Additional Payments to Hospitals. In addition to payments based on the DRG prospective payment rates, hospitals will receive payments for the following:

A) Atypically long or extraordinarily costly (outlier) cases, as described in Section 149.105.

B) Certain costs excluded from the prospective payment rate under subsection (a)(4) above.

C) The cost of serving a disproportionately high share of low income patients (as defined and determined in Section 149.125 149.125(a)(2)).

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Section 149.25(a)(5) (continued)

D) Uncompensated care costs (as defined and determined in Section 149.125 149.125(a)(3)).

E) ~~Trauma-center-costs~~ Specific inpatient payment adjustments (as defined and determined in Section 149.125 149.125(a)(4)).

F) Health care education payments (as defined and determined in Section 149.140).

G) Certified registered nurse anesthetist (CRNA) costs in accordance with Section 149.150(c)(3).

H) Kidney acquisition costs in accordance with Section 149.150(c)(5).

b) Discharges and Transfers

1) Discharges. A hospital inpatient is considered discharged when any of the following occurs:

A) The patient is formally released from the hospital, except when the patient is transferred to another hospital or a distinct part unit as described in Section 149.50(d) (see subsection (b)(2) below).

B) The patient dies in the hospital.

2) Transfers. A hospital inpatient is considered transferred when the patient is placed in the care of another hospital or a distinct part unit as described in Section 149.50(d).

3) Payment in Full to the Discharging Hospital. The hospital discharging an inpatient (subsection (b)(1)(A) above) is paid in full, in accordance with subsection (a)(2) above, unless the discharging hospital or distinct part unit is excluded from the DRG PPS as described in Section 149.50(b), (c) and (d). In the event the discharging hospital or distinct part unit is excluded or exempted from the DRG PPS, that hospital or distinct part unit shall receive payment in full in accordance with 89 Ill. Adm. Code 148.160, 148.170 or 148.250 through 148.300.

4) Payment to a Hospital Transferring an Inpatient to Another Hospital or Distinct Part Unit

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Section 149.25(b)(4) (continued)

- A) A hospital reimbursed under the DRG PPS that transfers an inpatient, under the circumstances described in subsection (b)(2), is paid a per diem rate for each day of the patient's stay in that hospital but the total reimbursement shall not exceed the amount that would have been paid under Section 149.100 if the patient had been discharged. The per diem rate is determined by dividing the appropriate prospective payment rate (as determined under Section 149.100) by the geometric length of stay for the specific DRG to which the case is classified.
- B) Except, if a discharge is classified into DRGs 385 or 985 (neonates, died or transferred to another acute care facility) or DRG 456 (burns, transferred to another acute care facility), and the hospital is reimbursed under the DRG PPS, the transferring hospital is paid in accordance with subsection (a)(2).
- C) A transferring hospital reimbursed under the DRG PPS may qualify for an additional payment for extraordinarily high cost cases that meet the criteria for cost outliers as described in Section 149.105.
- D) A hospital or distinct part unit excluded from the DRG PPS, as described in Section 149.50(b), (c) or (d), that transfers an inpatient under the circumstances described in subsection (b)(2) of this Section, is reimbursed in accordance with 89 Ill. Adm. Code 148.160, 148.170 or 148.250 through 148.300.
- c) Admissions Prior to September 1, 1991. With respect to admissions prior to September 1, 1991, hospitals will receive their per diem reimbursement rate that was in effect July 1, 1991, for each covered day of care provided through the discharge of the patient.
- d) DRG Classification System
 - 1) For rate periods beginning on or after October 1, 1992, the Department will utilize the DRG Groupers, as described in Section 149.5(c)(1), HCFA-Medicare grouper, Version 9-0, modified to handle additional DRGs and revised ICD-9-CM codes, as defined by the Department, to place claims into DRG payment classifications.
 - 2) The Department will define additional DRGs that, for hospitals designated as Level III perinatal centers by the Illinois Department of Public Health, replace DRG 385 (neonates, died or

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Section 149.25(d)(2) (continued)

transferred to another acute care facility), DRG 386 (extreme immaturity or respiratory distress syndrome, neonate), DRG 387 (prematurity with major problems) and DRG 389 (full term neonate with major problems).

(Source: Amended at 18 Ill. Reg. _____, effective February 25, 1994)

Section 149.50 Hospital Services Subject to and Excluded from the DRG Prospective Payment System

- a) Hospital Services Subject to the DRG Prospective Payment System
 - 1) Except for services described in Section 149.25(a)(4) and subsection (b)(2) below, all covered inpatient hospital services furnished to persons receiving coverage under the Medicaid Program are paid for under the DRG PPS.
 - 2) Inpatient hospital services will not be paid for under the DRG PPS under any of the following circumstances:
 - A) The services are furnished by a hospital (or distinct part hospital unit) explicitly excluded from the DRG PPS under subsections (c) through (d).
 - B) The services are furnished by a nonparticipating out-of-state hospital (as described in subsection (c)(5)).
 - C) The services are furnished by a hospital that elects to be reimbursed under special arrangements (as described in subsection (c)(6)) in the transition period of DRG PPS implementation.
 - D) The services are furnished by a sole community hospital (as defined in Section 149.125(b)) that has elected to be exempted from the DRG PPS in accordance with subsection (c)(7).
 - E) The payment for services is covered by a health maintenance organization (HMO).
 - b) Excluded and Exempted Hospitals and Hospital Units: General Rules
 - 1) Criteria. A hospital will be excluded from the DRG PPS if it meets the criteria for one or more of the classifications described in subsection (c) below.

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Section 149.50(b) (continued)

- 2) Alternate Reimbursement System. All excluded hospitals (and excluded distinct part hospital units, as described in subsection (d) below) are reimbursed under the Alternate Reimbursement Systems set forth in 89 Ill. Adm. Code 148.250 through 148.300 with the exception of those hospitals described in subsection (c)(8). The hospitals described in subsection (c)(8) are reimbursed in accordance with 89 Ill. Adm. Code 148.160 or 148.170, as appropriate.

c) Excluded Hospitals: Classifications. Hospitals that meet the requirements for the classifications set forth in this Section may not be reimbursed under the DRG Prospective Payment System.

- 1) Psychiatric Hospitals. A psychiatric hospital must:

- A) Be primarily engaged in providing, by or under the supervision of psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons; and
- B) Be enrolled with the Department as a psychiatric hospital to provide inpatient psychiatric services (category of service 21) and have a Provider Agreement to participate in the Medicaid Program.

- 2) Rehabilitation Hospitals. A rehabilitation hospital must:

- A) Hold a valid license as a physical rehabilitation hospital; and
- B) Be enrolled with the Department as a rehabilitation hospital to provide inpatient rehabilitation services (category of service 22) and have a Provider Agreement to participate in the Medicaid Program.

- 3) Children's Hospitals. A children's hospital must:

- A) Be engaged in furnishing services to inpatients who are predominately individuals under 18 years of age. Be a hospital devoted exclusively to caring for children. A hospital which includes a facility devoted exclusively to caring for children that is separately licensed as a hospital by a municipality shall be considered a children's hospital to the degree that the hospital's Medicaid care is provided to children; and

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Section 149.50(c)(3) (continued)

- B) Have a Provider Agreement to participate in the Medicaid Program.

- 4) Long Term Stay Hospitals. A long term stay hospital must:

- A) Not be a psychiatric hospital, as described in subsection (c)(1) above, a rehabilitation hospital as described in subsection (c)(2) above, or a children's hospital as described in subsection (c)(3) above and must have an average length of inpatient stay greater than 25 days: as computed by dividing the number of total inpatient days (less leave or pass days) by the number of total discharges for the most recent State fiscal year (i.e., Fiscal Year 1991 for Fiscal Year 1992 payments) for which complete information is available; and

- B) Have a Provider Agreement to participate in the Medicaid Program.

- 5) Hospitals Outside of Illinois that are Exempt from Cost Reporting Requirements. A hospital is excluded from the DRG PPS if it meets the following definition: a nonparticipating out-of-state hospital is a hospital from-out-of-state an out-of-state hospital that provides fewer than 100 Illinois Medicaid days annually, that does not elect to be reimbursed under this Part (the DRG Prospective Payment System), and that does not file an Illinois Medicaid cost report.

- 6) Hospitals Reimbursed Under Special Arrangements. Hospitals that, on August 31, 1991, had a contract with the Department under the ICARE Program, pursuant to Section 3-4 of the Illinois Health Finance Reform Act, may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care for services provided on or after September 1, 1991, subject to the limitations described in 89 Ill. Adm. Code 148.40(e) through 148.40(g) 148.40(f) through 148.40(h).

- 7) Sole Community Hospitals. Hospitals described in Section 149.125(b), which have elected to be exempted from the DRG PPS, subject to the limitations described in 89 Ill. Adm. Code 148.40(e) through 148.40(g) 148.40(f) through 148.40(h).

- 8) County-Owned Hospitals and State-Owned Hospitals Organized Under the University of Illinois Hospital Act. County-owned hospitals and State-owned hospitals located in an Illinois county with a population greater than three million and hospitals organized

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Section 149.50(c)(8) (continued)

under the University of Illinois Hospital Act are excluded from the DRG system and are reimbursed under unique hospital-specific reimbursement methodologies as described in 89 Ill. Adm. Code 148.160 and 148.170.

d) Excluded Distinct Part Hospital Units.

- 1) Distinct Part Psychiatric Units. With the exception of those hospitals described in subsections (c)(1) through (c)(8), a hospital enrolled with the Department to provide inpatient psychiatric services (category of service 21) shall be excluded from the DRG PPS for the reimbursement of such inpatient psychiatric services and shall be reimbursed in accordance with 89 Ill. Adm. Code 148.270(b).
- 2) Distinct Part Rehabilitation Units. With the exception of those hospitals described in subsections (c)(1) through (c)(8), a hospital enrolled with the Department to provide inpatient rehabilitation services (category of service 22) shall be excluded from the DRG PPS for the reimbursement of such inpatient rehabilitation services and shall be reimbursed in accordance with 89 Ill. Adm. Code 148.270(b).

(Source: Amended at 18 Ill. Reg. _____, effective February 25, 1994)

Section 149.75 Conditions for Payment Under the DRG Prospective Payment System

a) General Requirements

- 1) A hospital must meet the conditions of this Section to receive payment under the DRG PPS for inpatient hospital services furnished to persons receiving coverage under the Medicaid Program.
- 2) If a hospital fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medicaid clients, the Department may, as appropriate:
 - A) Withhold Medicaid payment (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or
 - B) Terminate the hospital's Provider Agreement.

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Section 149.75 (continued)

- b) Hospital Utilization Control. Hospitals and distinct part units that participate in Medicare (Title XVIII) must use the same utilization review standards and procedures and review committee for Medicaid as they use for Medicare. Hospitals and distinct part units that do not participate in Medicare (Title XVIII) must meet the utilization review plan requirements in 42 CFR, Ch. IV, Part 456, Subparts C, D, or E (October 1, 1991). Utilization control requirements for inpatient psychiatric hospital care in a psychiatric hospital, as defined in Section 149.50(c)(1), shall be in accordance with federal regulations at 42 CFR, Ch. IV, Part 456, Subpart G (October 1, 1991).
- c) Medical Review Requirements: Admissions and Quality Review

Hospital utilization review committees, a subgroup of the utilization review committee, or the hospital's designated professional review organization (PRO) shall review, on an ongoing basis, the following:

- 1) The medical necessity, reasonableness and appropriateness of inpatient hospital admissions and discharges.
- 2) The medical necessity, reasonableness and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of Section 149.105.
- 3) The validity of the hospital's diagnostic and procedural information.
- 4) The completeness, adequacy and quality of the services furnished in the hospital.
- 5) Other medical or other practices with respect to program participants or billing for services furnished to program participants.
- d) Medical Review Requirements: DRG Validation
 - 1) Physician attestation. Beginning with admissions on or after September 1, 1991, for which the discharge occurs on or after December 15, 1991, the attending physician must, shortly before, at, or shortly after discharge (but before a claim is submitted), attest to the principal diagnosis, secondary diagnoses, and names of major procedures performed. The information must be in writing in the medical record and, except as provided in subsection (d)(2) below, the physician must sign the statement. Below the diagnostic and procedural information, and on the same page, the following statement must immediately

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Section 149.75(d)(1) (continued)

precede the physician's dated signature: "I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge." The physician's name must be typed or clearly printed and appear on the same page as the physician's signature.

- 2) Alternative signature requirement. The attending physician's signature, along with the other information required in subsection (d)(1), may be provided by electronic means through a hospital data system if the hospital's Title XVIII (Medicare) intermediary has determined that the hospital data system meets the guidelines established by the Health Care Financing Administration, U.S. Department of Health and Human Services, under the Medicare Program.

- 3) DRG Validation. The Department or its designee may require and perform prepayment review and/or postpayment review of specific diagnosis and procedure codes.

4) Sample Reviews

- A) The Department, or its designee, may review a random sample of discharges to verify that the diagnostic and procedural coding, submitted by the hospital and used by the Department for DRG assignment, is substantiated by the corresponding medical records.

- B) Code validation must be done on the basis of a review of medical records and, at the Department's discretion, may take place at the hospital or away from the hospital site.

5) Revision of Coding

- A) If the diagnostic and procedural information, attested to by the attending physician, is found to be inconsistent with the hospital's coding, the hospital shall be required to provide the appropriate coding and the Department shall recalculate the payment on the basis of the revised coding.

- B) If the information attested to by the physician as stipulated under subsection (d)(5)(A) is found not to be consistent with the medical record, the hospital shall be required to provide the appropriate coding and the Department shall recalculate the payment on the basis of the revised coding.

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Section 149.75 (continued)

- e) Medical Review Requirements: The Department, or its designee, may conduct pre-admission, concurrent, pre-payment, and/or post-payment reviews of:

- 1) The medical necessity, reasonableness and appropriateness of inpatient hospital admissions and discharges.
- 2) The quality and/or the nature of the utilization of health services.
- 3) The medical necessity, reasonableness and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of Section 149.105.
- 4) The validity of the hospital's diagnostic and procedural information.
- 5) The completeness, adequacy and quality of the services furnished in the hospital.
- 6) Other medical or other practices with respect to program participants or billing for services furnished to program participants.
- f) Hospitals shall be notified at least thirty (30) days in advance of any pre-admission, concurrent, or pre-payment review requirements imposed by the Department.

- q) Denial of Payment as a Result of Admissions, Length of Stay, Transfers and Quality Review

- 1) If the Department determines that a hospital has misrepresented admissions, length of stay, discharges, or billing information, or has taken an action that results in the unnecessary admission or inappropriate discharge of a program participant, unnecessary multiple admissions of a program participant, unnecessary transfer of a program participant, or other inappropriate medical or other practices with respect to program participants or billing for services furnished to program participants, the Department may, as appropriate:

- A) Deny payment (in whole or in part) with respect to inpatient hospital services provided with respect to such an unnecessary admission, inappropriate length of stay or discharge, subsequent readmission or transfer of an individual.

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Section 149.75(g)(1) (continued)

B) Require the hospital to take action necessary to prevent or correct the inappropriate practice.

C) Perform prepayment review in accordance with 89 Ill. Adm. Code 148.240(c) 148.240(a).

2) When payment with respect to the discharge of an individual patient is denied by the Department, or its designee, under subsection (g)(1)(A), a reconsideration will be provided within 30 days, upon the request of a practitioner or provider, if such request is the result of the designee's own medical necessity or appropriateness of care denial determination and is received within 60 days of the Advisory Notice. The date of the Advisory Notice is counted as day one.

3) A determination under subsection (g)(1) above, if it is related to a pattern of inappropriate admissions, length of stay and billing practices that has the effect of circumventing the prospective payment system, may result in actions specified in subsection (a)(2) above.

h) Furnishing of Inpatient Hospital Services Directly or Under Other Arrangements

1) The applicable payments made under the PPS are payment in full for all inpatient hospital services other than for the services of nonhospital-based physicians to individual program participants and the services of certain hospital-based physicians as described in subsections (h)(1)(B)(i) through (h)(1)(B)(v) below.

A) Hospital-based physicians who may not bill separately on a fee-for-service basis:

i) A physician whose salary is included in the hospital's cost report for direct patient care may not bill separately on a fee-for-service basis.

ii) A teaching physician who provides direct patient care may not bill separately on a fee-for-service basis if the salary paid to the teaching physician by the hospital or other institution includes a component for treatment services.

B) Hospital-based physicians who may bill separately on a fee-for-service basis:

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Section 149.75(h)(1)(B) (continued)

i) A physician whose salary is not included in the hospital's cost report for direct patient care may bill separately on a fee-for-service basis.

ii) A teaching physician who provides direct patient care may bill separately on a fee-for-service basis if the salary paid to the teaching physician by the hospital or other institution does not include a component for treatment services.

iii) A resident may bill separately on a fee-for-service basis when, by the terms of his or her contract with the hospital, he or she is permitted to and does bill private patients and collect and retain the payments received for those services.

iv) A hospital-based specialist who is salaried, with the cost of his or her services included in the hospital reimbursement costs, may bill separately on a fee-for-service basis when, by the terms of his or her contract with the hospital, he or she may charge for professional services and do, in fact, bill private patients and collect and retain the payments received.

v) A physician holding a nonteaching administrative or staff position in a hospital or medical school may bill separately on a fee-for-service basis to the extent that he or she maintains a private practice and bills private patients and collects and retains payments made.

2) Charges are to be submitted on a fee-for-service basis only when the physician seeking reimbursement has been personally involved in the services being provided. In the case of surgery, it means presence in the operating room, performing or supervising the major phases of the operation, with full and immediate responsibility for all actions performed as a part of the surgical treatment.

(Source: Amended at 18 Ill. Reg. _____, effective February 25, 1994)

Section 149.100 Basic Methodology for Determining DRG Prospective Payment Rates

a) DRG Classification and Weighting Factors

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Section 149.100(a) (continued)

Section 149.100(a)(2)(B)(i) (continued)

1) DRG Classification. For the rate period beginning October 1, 1992, the Department will utilize the DRG Groupers as described in Section 149.5(c)(1), to classify classification of inpatient hospital discharges by diagnosis related groups (DRGs) as defined by federal regulation for the Medicare Program (42 CFR 412) in effect on September 1, 1992, with modifications deemed appropriate due to the differences in the Medicare and Medicaid patient populations and Illinois Medicaid policy.

listed as otherwise reimbursed under Section 149.150(c), updated to the current rate year using the national hospital market basket price proxies (DRI) DRG factors (defined in 89-111-Adm-Code-148-270), and the hospital's cost to charge ratio, as derived from the hospital's most recent audited base-year cost report (e.g., Calendar Year 1989 for Fiscal Year 1992), divided by the number of discharges for that DRG.

2) DRG Weighting Factors

A) Except as provided in subsections (a)(2)(B) through (a)(2)(E) below, the Illinois Medicaid weighting factor for each DRG shall equal the Medicare weighting factor, as described in Section 149.5(c)(2), for that group, in effect on September 1, 1992, multiplied by a fraction, the numerator of which is the Medicaid geometric mean length of stay and the denominator of which is the Medicare geometric mean length of stay for that group. In making that calculation, the Department shall:

i) Use the Medicare geometric mean length of stay for each diagnostic related group as determined by the Health Care Financing Administration of the United States Department of Health and Human Services.

ii) Calculate the Medicaid geometric mean length of stay for each diagnostic related group using the same methodology employed to calculate the Medicare geometric mean length of stay and using data obtained from the Illinois Health Care Cost Containment Council or the Department's data bases.

B) The Illinois weighting factors for neonatal discharges (Medicare-defined DRGs 385-391 and Illinois-defined DRGs for Level III perinatal centers) shall be the product of the ratio of the mean cost per discharge (defined below) of the given DRG to the mean cost per discharge for DRG 391 (normal newborn) and the Medicare scaling factor (defined below), such that the Illinois and Medicare weighting factors for DRG 391 are the same.

i) Mean cost per discharge, for any DRG, is defined as the sum of the product of charges, as reported by a hospital on claims paid by the Department, less costs

ii) Medicare scaling factor is defined as the Medicare weighting factor for DRG 391 (normal newborns).

C) The Illinois weighting factors for psychiatric discharges (DRGs 424-432) shall be computed as specified in subsections (a)(1) and (a)(2) except, prior to computing the Medicaid geometric mean length of stay for those DRGs, all lengths of stay longer than three (3) days are to be set at three (3) days.

D) The Illinois weighting factors for DRGs that will not be paid through the DRG PPS are zero (0.0000). Those include DRG 103, heart transplant; DRG 436, alcohol/drug dependence with rehabilitation therapy; DRG 462, rehabilitation; DRG 480, liver transplant; DRG 481, bone marrow transplant.

E) Except for DRGs otherwise specified in subsections (a)(2)(B) through (a)(2)(D), the Illinois weighting factors for DRGs for which available historic discharge data are sparse, fewer than 100 records, shall be computed using an alternate methodology.

i) For rate periods the rate period beginning on or after October 1, 1992, for those DRGs with 32 or more records available, the Illinois weighting factor shall be set at the midpoint between the weight calculated using the methodology in subsection (a)(2)(A) and the Medicare weighting factor, as described in Section 149.5(c)(2) in effect on September 1, 1992.

ii) For those DRGs with fewer than 32 records available, the Illinois weighting factor shall be set equivalent to the Medicare weighting factor, as described in Section 149.5(c)(2) in effect on September 1, 1992.

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Section 149.100(a) (continued)

- 3) Assignment of Discharges to DRGs. The Department will establish a methodology for classifying specific hospital discharges within DRGs which ensures that each hospital discharge is appropriately assigned to a single DRG, based on essential data abstracted from the inpatient bill for that discharge.

A) The classification of a particular discharge will, as appropriate, be based on the patient's age, sex, principal diagnosis (that is, the diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed, and discharge status.

B) Each discharge will be assigned to only one DRG (related, except as provided in subsection (a)(3)(C), to the patient's principal diagnosis) regardless of the number of conditions treated or services furnished during the patient's stay.

C) When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the bill will be subject to prepayment review for validation and reverification. The Department's DRG classification system will provide a DRG, and an appropriate weighting factor, for cases for which the unrelated diagnosis and procedure are confirmed.

4) Review of DRG Assignment

A) A hospital has 60 days after the date of the remittance advice indicating initial assignment of a discharge to a DRG to request a review of the assignment. The hospital may submit additional information as a part of its request.

B) The Department shall review the hospital's request and any additional information and decide whether a change in the DRG assignment is appropriate. If the Department decides that a higher-weighted DRG should be assigned, it must request the Department's peer review organization to review the case to verify the change in DRG assignment.

C) Following the 60-day period described in subsection (a)(4)(A) above, the hospital may not submit additional information with respect to the DRG assignment or otherwise revise its claim.

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Section 149.100 (continued)

b) Illinois Rates for Admissions ~~on or after October 1, 1992~~

1) Reimbursement to hospitals for claims for admissions occurring prior to October 1, 1992, shall be calculated and paid in accordance with the statutes and administrative rules governing the time period when the services were rendered. The payments described in Sections 149.5 through 149.150 149.325 and 89 Ill. Adm. Code 148.250 through 148.300 shall be effective for admissions on and after October 1, 1992, subject to 89 Ill. Adm. Code 148.20(b) and Section 149.5(b).

2) The payments described in 89 Ill. Adm. Code 148.82 148.80 shall be effective for services provided on or after July 1, 1992.

c) Determining Prospective Payment Rates.

1) Federal/Regional Blended Rate Per Discharge

A) ~~For the rate period beginning October 1, 1992, except as specified in subsection (c)(1)(B) below, the Department shall reimburse hospitals for inpatient services at the federal/regional blended rate per discharge for the Medicare Program, which includes the hospital-specific portion as described in subsection (c)(2) below, if applicable, in effect on September 1, 1992, and as computed by the PPS Pricer, as described in Section 149.5(c)(3) Version-92-0.~~

B) ~~In the case of a hospital that was not determined by the Department to be a rural hospital at the beginning of the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), but was subsequently reclassified by the Department as a rural hospital, as described in 89 Ill. Adm. Code 148.25(g)(3), on July 15, 1993:~~

- i) ~~Effective with admissions occurring on October 1, 1993, and for the duration of the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the Department shall recompute such hospital's DRG PPS payment rate using the rural hospital federal/regional, rural wage adjusted, blended rate per discharge in effect on September 1, 1992, under the Medicare Program.~~

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Section 149.100(c)(1)(A) (continued)

Section 149.100(d) (continued)

ii) Effective with admissions occurring on or after the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Department shall compute such hospital's DRG PPS payment rate using the rural hospital federal/regional, rural wage adjusted, blended rate per discharge in effect 90 days prior to the date of admission, under the Medicare Program.

Ill. Adm. Code 148.120) to ensure that aggregate payments do not exceed the amount that can reasonably be estimated would have been paid under Medicare payment principles, in compliance with 42 CFR 447.272, Application of Upper Payment Limits.

(Source: Amended at 18 Ill. Reg. ____, effective February 25, 1994)

2) Hospital-Specific Portion

The hospital-specific portion is defined as the specific status and any applicable add-ons under the Medicare Program in recognition of sole community hospitals, rural referral centers, Medicare dependent hospitals, and rural hospitals deemed urban.

3) DRG PPS Base Rate

The DRG PPS base rate shall be defined as the sum of the amounts computed under subsections (c)(1) and (c)(2), multiplied by the Illinois weighting factor assigned to the DRG into which the case has been classified.

4) Payment Adjustments

In addition to the DRG PPS base rate defined in subsection (c)(3), hospitals shall receive applicable outlier adjustments, in accordance with Section 149.105; applicable adjustments a-per case-add-on for health care education payments, in accordance with Section 149.140; applicable adjustments per case-add-on for indirect medical education costs, capital costs, direct medical education costs, and CRNA costs in accordance with Section 149.150(c); applicable adjustments for disproportionate share, in accordance with 89 Ill. Adm. Code Section 148.120; applicable adjustments for uncompensated care, in accordance with 89 Ill. Adm. Code Section 148.150; various specific inpatient payment adjustments, as applicable adjustments for trauma-admissions, in accordance with 89 Ill. Adm. Code Section 148.290 148.190; and, on a retrospective basis, any applicable adjustment for kidney acquisition costs in accordance with Section 149.150(c)(5).

d) Application of Upper Payment Limits.

The Department shall adjust each of the prospective payment rates determined under subsection (c) above (with the exception of disproportionate share payment adjustments made in accordance with 89

Section 149.105 Payment For Outlier Cases

a) General Provisions

1) Basic-Rule

A) Except as provided in subsections (a)(3) and (a)(4) of this section subsections (a)(1) and (a)(2), the Department provides for additional payment, approximating a hospital's marginal cost of care beyond thresholds specified by the Department, to a hospital for covered inpatient hospital services furnished to a Medicaid client, if either of the following conditions in the following subsections (A) or (B) apply:

i) The client's length of stay (including up to three administrative days) exceeds the day outlier threshold, determined by the Department, for the appropriate applicable DRG.

A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the threshold is set at the lesser of the geometric mean length of stay plus 27 days, or the geometric mean length of stay plus three (3) standard deviations.

B) For rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Department shall utilize the geometric mean length of stay plus the lesser of three standard deviations, or the Medicare day outlier cutoff threshold in effect 90 days prior to the date of admission, adjusted by a factor, the numerator of which is the Medicaid geometric length of stay, and the denominator of which is the average Medicare geometric mean length of stay.

2) The hospital's charges for covered services furnished to the client, adjusted to cost by applying a cost-to-charge ratio, as

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Section 149.105(a)(2) (continued)

described in subsection (c)(3) of this Section, exceed the greater of:

- A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), \$34,000 as adjusted for the hospital's labor market, or the hospital's DRG PPS base rate as described in Section 149.100(c)(1) (b)(2)(C) multiplied by two (2).
- B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Department shall utilize the Medicare established cost outlier cutoff threshold in effect 90 days prior to the date of admission. The Medicare outlier threshold shall be adjusted by a factor, the numerator of which is the Medicaid geometric length of stay, and the denominator of which is the Medicare geometric mean length of stay.

3)B) The Department will provide cost outlier payments to a transferring hospital reimbursed under the DRG PPS that does not receive payment under subsection (b) of this Section for discharges specified in Section 149.25(b)(4)(B), if the hospital's charges for covered services furnished to the client, adjusted to cost by applying a cost-to-charge ratio, as described in subsection (c)(3), exceed:

- A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the greater of the criteria specified in subsection (a)(2)(A) of this Section (a)(1)(A)(i).

- B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the criteria specified in subsection (a)(2)(B) of this Section.

4)C) The Department will not provide outlier payments for:

- A) Discharges classified as psychiatric care (DRGs 424-432). Such care provided by other than hospitals or distinct part units enrolled with the Department to provide psychiatric care (category of service 21) is limited to emergency treatment, to last no longer than three days.
- B) Discharges assigned to DRGs with an Illinois weighting factor of zero (0.0000).

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Section 149.105(a)(5) (continued)

5)2) The Department or its designee may review outlier cases on a prepayment or postpayment review basis. The charges for any services identified as noncovered through this review will be denied and any outlier payment having been made for those services will be recovered, as appropriate, after a determination as to the provider's liability has been made. If the Department or its designee finds a pattern of inappropriate utilization by a hospital, all outlier cases from that hospital are subject to medical review, and this review may be conducted prior to payment until the Department or its designee determines that appropriate corrective actions have been taken. The Department, or its designee, must review and approve, to the extent required by the Department:

- A) The admission was medically necessary and appropriate.
- B) The medical necessity and appropriateness of the admission and outlier services in the context of the entire stay.
- C) The services were ordered by the physician, actually furnished, and nonduplicatively billed.
- D) The validity of the diagnostic and procedural coding.
- E) The granting of up to three administrative (grace) days during which the hospital is seeking an appropriate setting into which to discharge a nonacute patient.

b) Payment for Extended Length-of-Stay Cases (Day Outliers)

- 1) If the hospital stay includes covered days of care beyond the applicable threshold criterion, the Department will make an additional payment, on a per diem basis, to the discharging hospital for those days and the transferring hospital for DRG's 385, 456, or 985 only. A special request or submission is not necessary to initiate this payment.
- 2) Except as provided in subsection (d) subsections (b)(3)-(f) of this Section, and subject to the limitations described in subsection (e) of this Section, the per diem payment made under subsection (b)(1) is derived by first taking 60 percent of the per diem payment for the applicable DRG, as calculated by dividing the DRG PPS base rate, determined under Section 149.100(c)(3), 89 Ill. Adm. Code 149.100 by the mean length-of-stay for that DRG.

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Section 149.105(b) (continued)

- 3) ~~The per diem payment made under subsection (b)(1) for burn discharge (DRGs 456-460) is derived under the provisions of subsection (b)(2), except that the calculation is 90 percent of the per diem payment of the applicable DRG.~~

- 3)4) Any days in a covered stay identified as noncovered reduce the number of days reimbursed at the day outlier rate but not to exceed the number of days that occur after the day outlier threshold.

c) Payment for Extraordinarily High Cost Cases (Cost Outliers)

- 1) If the hospital charges, as adjusted by the method specified in subsection (c)(3) exceed the applicable threshold criterion, the Department will make an additional payment to the hospital to cover those costs. A special request or submission is not necessary to initiate this payment.

- 2) The Department will reimburse the cost of the discharge on the billed charges for covered inpatient services, adjusted by a cost-to-charge ratio as described in subsection (c)(3), subject to the limitations described in subsections (c)(4) and (e) of this Section.

- 3) The cost-to-charge ratio used to adjust covered charges is computed at the beginning of each rate period, as described in 89 Ill. Adm. Code 148.25(g)(2), annually by the Department for each hospital based on the hospital's base fiscal year. Statewide cost-to-charge ratios are used in those instances in which a hospital's cost-to-charge ratio falls outside reasonable parameters or cannot be computed due to a lack of information (e.g., a new hospital for which the Department is not in possession of the required historical information).

- 4) If any of the services are determined to be noncovered, the charges for those services will be deducted from the requested amount of reimbursement but not to exceed the amount claimed above the cost outlier threshold.

- 5) Except as provided in subsection (c)(6), the additional amount is 75 percent of the difference between the hospital's adjusted cost for the discharge (as determined under subsection (c)(3)) and the threshold criteria established under subsection (a)(1)(A)(ii), subject to the limitations described in subsections (c)(4) and (e) of this Section.

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Section 149.105(c) (continued)

- 6) The additional payment amount for burn cases (DRGs 456-460) is computed under the provisions of subsection (c)(5), except that the payment is 90 percent of the difference between the hospital's adjusted cost for the discharge and the threshold criteria.

- d) Payment for Extraordinarily High Cost Day Outliers. If a discharge qualifies for an additional payment under the provisions of both subsections (b) and (c), the additional payment is subject to the limitations described in subsection (e) of this Section, the greater of the following:

- 1) The payment computed under subsection (b) above.

- 2) The payment computed under subsection (c) above.

- e) Outlier Payment Limitation. Notwithstanding any other provisions of this Section, the total reimbursement paid by the Department excluding payments described in 89 Ill. Adm. Code 148.120 for a claim qualifying for an outlier payment under this Section shall not exceed the total covered inpatient charges.

(Source: Amended at 18 Ill. Reg. _____, effective February 25, 1994)

Section 149.125 Special Treatment of Certain Facilities

a) General Rules

- 1) Sole Community Hospitals. Hospitals defined as sole community hospitals shall, under subsection (b) below, shall have the choice of being reimbursed under the DRG PPS methodology, as described in Sections 149.5 through 149.150, or the Department's Alternate Reimbursement methodology as described in 89 Ill. Adm. Code 148.250 through 148.300, in accordance with the provisions of 89 Ill. Adm. Code 148.40(f) through (h).

- 2) Hospitals that Serve a Disproportionate Share of Low Income Patients. The Department shall make additional payments to hospitals that serve a disproportionate share of low income patients. The criteria and methodologies for such additional payments are set forth in 89 Ill. Adm. Code 148.120 and include applicable additional payments for targeted severe care and critical access care.

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Section 149.125(a) (continued)

- 3) Uncompensated Care Adjustments. The Department shall make an additional payment to hospitals that provide equal access to low income persons. The criteria and methodology for this additional payment are set forth in 89 Ill. Adm. Code 148.150.
- 4) Specific Inpatient Payment Trauma-Center Adjustments. The Department shall make specific additional payments to applicable hospitals trauma-centers as set forth in 89 Ill. Adm. Code 148.290 148.290(e).

- b) Criteria for Classification as a Sole Community Hospital. "Medicaid Sole Community Provider" means a hospital that meets one of the following criteria:

1) Medicare Program Designation

- A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), any Any hospital designated as a "sole community provider" by the U.S. Department of Health and Human Services for purposes of reimbursement under the federal Medicare Program effective September 1, 1992, or
- B) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(B), any hospital designated as a "sole community provider" by the U.S. Department of Health and Human Services for purposes of reimbursement under the federal Medicare Program effective 90 days prior to the date of admission.

2) Primary Service Area Designation

- A) Any rural hospital, as described in 89 Ill. Adm. Code 148.25(g)(3), located outside of a metropolitan-statistical area that serves 55 percent or more of the Medicaid patients residing within the hospital's primary service area for the provision of inpatient hospital services.
- B) "Primary service area" means the geographic area defined by U.S. Postal Service Zip Codes in which 50 percent or more of a hospital's inpatients reside.
- C) The determination of sole community provider status under this subsection (b) shall be made prior to the rate period, as described in 89 Ill. Adm. Code 148.25(g)(2).

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Section 149.125(b)(2) (continued)

- c) The data used to make this determination will be from the Illinois Health Care Cost Containment Council (IHCCC) for the most recent four quarters for which information is available.

(Source: Amended at 18 Ill. Reg. _____, effective February 25, 1994)

Section 149.140 Methodology for Determining Primary Care Access Health Care Education Payments

- a) Payments will be made to qualifying teaching hospitals for the purpose of encouraging medical schools and affiliated teaching hospitals to increase the number and to promote the education of primary health care professionals and the placement of those professionals in areas of the State that suffer a shortage of medical professionals.
- b) Definitions.

- 1) "Full-time equivalent countable resident" means a resident that meets both of the following criteria:

- A) A resident that is, as defined by the federal Department of Health and Human Services, allowed to be reported on the Medicare Cost Report when calculating Graduate Medical Education (GME) payments, as of October 1, 1993, and as of the first day of any Medicare rate year subsequent to the rate period in effect as of April 1, 1994.

- B) A resident that is, as of October 1, 1993, and as of the first day of any Medicare rate year subsequent to the rate period in effect as of April 1, 1994, in the first, second, third or fourth year of their first residency training program.

- 2) "Full-time equivalent resident" means, for the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A) and for the first subsequent rate period as described in 89 Ill. Adm. Code 148.25(g)(2)(B), residents, as defined by the federal Department of Health and Human Services, and allowed to be reported on the Medicare cost report on file with the Department for the latest cost report period ending between nineteen-(19) and thirty-(30) months prior to the beginning of the fiscal year in which the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A) begins.

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Section 149.140(b) (continued)

- 3) "Full-time equivalent qualified rotation" means one full-time equivalent countable resident that works full-time, or its proportional equivalent, in any qualified setting.
- 4) "Full-time equivalent rotation" means one full-time equivalent countable resident that works full-time, or its proportional equivalent, in any residency location.
- 5) "Major academic hospital" means:
- A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), a hospital located in the State of Illinois, with at least three-hundred-fifty-(350) acute care, inpatient beds and at least one-hundred-thirty-(130) full-time equivalent residents. The source of this information on acute-care, inpatient beds will be the most recent available American Hospital Association Guide.
 - B) For subsequent rate periods not described in subsection (b)(5)(A) above, a hospital, located in the State of Illinois, with at least 350 acute care, inpatient beds and at least 130 full-time equivalent residents. The source of this information will be the most current Illinois Department of Public Health published report entitled "Bed Count, Average Length of Stay, Average Daily Census and Percent Occupancy for Non-Federal Hospitals in Illinois", which is available to the Department 60 days preceding a rate period, as described in 89 Ill. Adm. Code 148.25(g)(2)(B) that is not described in subsection (b)(5)(A) above. Inpatient beds shall include total beds, excluding any used for substance abuse, long term care or swing beds. The source of information on full-time equivalent residents will be the most recent available Medicare Cost Report.

- 6) "Primary care clinic" means any hospital sponsored or affiliated practice site in which at least 50 per centum of patient visits to the clinic are for primary care, or meets one or more of the following criteria:
- A) At least 50 per centum of all staff physicians (including salaried, contractual, and part-time) routinely provide obstetric, pediatric, internal medicine, or family practice care in the clinic setting,

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Section 149.140(b)(6) (continued)

- B) The clinic enrolls in the Healthy Moms/Healthy Kids program and meets the following criteria:
 - i) The clinic accepts 1,000 or more pregnant women for obstetrical care through the Healthy Moms/Healthy Kids program between July 1, 1993, and June 30, 1994.
 - ii) The clinic accepts 1,250 or more pregnant women for obstetrical care through the Healthy Moms/Healthy Kids program between July 1, 1994, and June 30, 1995.
 - iii) The clinic accepts 1,500 or more pregnant women for obstetrical care through the Healthy Moms/Healthy Kids program between July 1, 1995, and June 30, 1996, and each year thereafter.
- C) The clinic enrolls in the Healthy Moms/Healthy Kids program and meets the following criteria:
 - i) The clinic accepts 3,000 or more women and children for primary care services through the Healthy Moms/Healthy Kids program between July 1, 1993, and June 30, 1994.
 - ii) The clinic accepts 3,750 or more women and children for primary care services through the Healthy Moms/Healthy Kids program between July 1, 1994, and June 30, 1995.
 - iii) The clinic accepts 4,500 or more women and children for primary care services through the Healthy Moms/Healthy Kids program between July 1, 1995, and June 30, 1996, and each year thereafter.
- 7) A primary care clinic does not include clinics or facilities established for emergency room usage.
- 8) "Qualified rotation setting" means any of the following:
 - A) A primary care clinic that meets one of the following criteria: has thirty five-(35) per centum or more of its annual patients eligible for medical assistance.
 - i) A primary care clinic that has 20 per centum or more of its annual patients eligible for medical assistance.

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Section 149.140(b)(8) (continued)

- ii) A primary care clinic that has 25,000 or more of its annual patient visits eligible for medical assistance.
- iii) A primary care clinic that has 5,000 or more of its annual patient visits eligible for medical assistance and a 10 per centum or more increase in its annual patients eligible for medical assistance from one year to the next.
- B) A primary care clinic that pledges to serve 500 or more individuals participating in the Department's Healthy Moms/Healthy Kids program.

CE) A federally qualified health center.

PC) A rural health center.

9) "Qualified rotation ratio" means the ratio of the total full-time equivalent qualified rotation to the total full-time equivalent rotation of all countable residents.

10) "Medicare rate year" means any Medicare rate year in effect as defined by the federal Health Care Finance Administration (HCFA).

c) Initiative Goals. The goals of this initiative are to direct State resources into incentives that will:

- 1) Increase the number of primary health care professionals trained in community primary care settings.
- 2) Increase the number of primary health care professionals providing thorough medical services to persons eligible for medical assistance.
- 3) Decrease the number of non-urgent hospital emergency room visits.
- 4) Promote cooperation among medical schools, major teaching hospitals, and primary care providers to develop programs that will:
 - A) Encourage medical students to select primary care specialties.
 - B) Establish and staff clinics that are located in medically underserved areas or underserved Medicaid areas.

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Section 149.140(c)(4) (continued)

C) Promote the use of preventive care.

d) Participation Requirements.

- 1) Major academic hospitals must enroll with the Department to participate in the initiative.
- 2) Hospitals receiving payments under this initiative are to use these payments for the establishment of new programs or the enhancement of existing programs that will place residents in qualified rotation settings and achieve the goals described in subsection (c) above.
- 3) Hospitals receiving payments under this incentive must comply with reporting requirements as described in subsection (f) below.

e) Payment methodology. For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), payments payable will be made as an add-on for any DRG PPS discharge from a participating hospital. The amount of that payment shall be a per discharge amount which will be the quotient of the hospital-specific incentive level divided by the number of DRG PPS discharges expected, by the Department, to occur during the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A). For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), payment adjustments will be made for any DRG PPS discharge from a participating hospital; however, the amount of the payment adjustment shall be a per diem amount which will be the quotient of the hospital-specific incentive level divided by the number of DRG PPS inpatient days expected, by the Department, to occur during the applicable rate period, as described in 89 Ill. Adm. Code 148.25(g)(2)(A). The hospital-specific incentive level shall be determined as follows:

- 1) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), periods beginning on or after October 1, 1992 and for the first subsequent rate period described in 89 Ill. Adm. Code 148.25(g)(2)(B), the hospital-specific incentive level shall be the product of the annual resident funding factor, which for rate periods beginning on or after October 1, 1992, shall be \$7,500, and the number of countable residents, which is the lesser of:
 - A) The total number of full-time equivalent residents.
 - B) Sixty (60) per centum of the number of acute care inpatient beds.

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Section 149.140(e) (continued)

- 2) For subsequent rate periods not described in subsection (e)(1) above, the hospital-specific incentive level shall be the product of the following three factors: Each-as-used-to-qualify the-hospital-as-a-major-teaching-institution.
- A) The annual resident funding factor, which shall be \$8,500.
- B) The lesser of:
 - i) The total number of full-time equivalent countable residents.
 - ii) Sixty per centum of the number of acute care inpatient beds, as determined in accordance with subsection (b)(5)(B) of this Section.
- C) The quotient of the qualified rotation ratio divided by the Department's qualified rotation goal.
- 3) The Department's qualified rotation goals are as follows:
 - A) Three per centum of the total full-time equivalent rotation time from October 1, 1993, through the day prior to any Medicare rate year, as described in subsection (b)(10) above, in effect as of April 1, 1994.
 - B) Four per centum of the total full-time equivalent rotation time of the Medicare rate year beginning on or after January 1, 1995.
 - C) Six per centum of the total full-time equivalent rotation time of the Medicare rate year beginning on or after January 1, 1996.
 - D) Nine per centum of the total full-time equivalent rotation time of the Medicare rate year beginning on or after January 1, 1997.
 - E) Twelve per centum of the total full-time equivalent rotation time of the Medicare rate year beginning on or after January 1, 1998.
- 4) Payments for rotation goals shall begin with the Medicaid rate year that begins subsequent to the conclusion of a rotation goal.

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- 5) Thirty days prior to the beginning of each rate period, hospitals receiving payments under this Section must provide the Department with data necessary to determine total rotation time and the rotation time in qualified settings for the months within a rotation goal.
 - 6) Payment Adjustment Cap. The aggregate payments under this Section shall be capped at \$17,800,000 per rate period. Reimbursement to each hospital receiving payments under this Section shall also be capped at 125 per centum of the product of countable residents multiplied by the annual resident funding factor. If aggregate payments exceed \$17,800,000, payments to each participating major academic hospital will be adjusted in proportion to not exceed the total payments under this Section for the rate period.
 - 7) Appeal Process. Hospitals receiving payments under this Section may appeal the amount of their payments in accordance with 89 Ill. Adm. Code 148.310(a)(3).
 - f) Reporting requirements. Participating hospitals must provide the Department with data and other information the Department deems necessary to determine eligibility for participation, and to monitor and evaluate this initiative. This information may include, but not be limited to:
 - 1) The names and program year of individual residents.
 - 2) Data maintained for residency review committees.
 - 3) Quarterly data necessary to determine the actual percentage of countable resident time spent in qualified rotation settings.
 - 4) Quarterly data necessary to determine if certain facilities meet the defined requirements of a qualified rotation setting.
- (Source: Amended at 18 Ill. Reg. _____, effective February 25, 1994)
- Section 149.150 Payments to Hospitals Under the DRG Prospective Payment System
- a) Total Medicaid Payment. Under the DRG PPS, the total payment for inpatient hospital services furnished to a Medicaid client by a hospital will equal the sum of the payments listed in subsections (b) through (c). In addition to the payments listed in subsections (b)

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Section 149.150(a) (continued)

through (c) of this Section, hospitals shall also receive applicable disproportionate share adjustments in accordance with 89 Ill. Adm. Code 148.120, if applicable, uncompensated care adjustments in accordance with 89 Ill. Adm. Code 148.150, if applicable, and various specific inpatient payment adjustments ~~trauma-center~~-adjustments in accordance with 89 Ill. Adm. Code 148.290 148-290(e), if applicable.

b) Payments Determined on a Per Case Basis. A hospital will be paid on a per case basis (with the exception of kidney acquisition costs) the following amounts:

1) the appropriate DRG PPS rate for each discharge as determined in accordance with Section 149.100(c) 149.100(b)(2).

2) The appropriate outlier payment amounts determined under Section 149.105.

3) Capital related costs as determined under subsection (c)(1)(A) (e)(1) below.

4) Direct medical education costs as determined under subsection (c)(2)(A) (e)(2) below.

5) Indirect medical education costs as determined under subsection (c)(3) below.

6) Anesthesia services of hospital employed nonphysician anesthesiologists (Certified Registered Nurse Anesthetists or "CRNAs") as set forth in Section 6132(a) of the Omnibus Budget Reconciliation Act of 1989 and in accordance with subsection (c)(4)(A) (e)(4).

7) Kidney acquisition costs in accordance with subsection (c)(5).

8) Primary care access health care education payments, if applicable, in accordance with Section 149.140.

c) Payments for Capital, Direct Medical Education, Indirect Medical Education, CRNA, and Kidney Acquisition Costs. For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A) these costs shall be paid on a per case basis, with the exception of kidney acquisition costs. For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), these costs shall be paid on a per diem basis. With the exception of kidney acquisition costs, Payments for these costs and shall be calculated as follows:

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Section 149.150(c) (continued)

1) Capital Related Costs

A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A):

i)A) The capital related cost per diem shall be calculated by taking the hospital's total capital related costs as reported on the hospital's latest audited Medicare cost report on file with the Department for the base period as defined in 89 Ill. Adm. Code 148.25(g)(1), divided by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national total hospital market basket price proxies (DRI).

ii)B) These two trended capital related cost per diems are then added together and divided by two to calculate the hospital's adjusted capital related cost per diem.

iii)C) The adjusted capital related cost per diem amount, as calculated in subsection (c)(1)(A)(ii) (e)(1)(B) above, shall be rank ordered for all hospitals and capped at the 80th percentile.

iv)D) Each hospital shall receive a per case add-on for capital related costs which shall be equal to the amount calculated in subsection (c)(1)(A)(ii) or subsection (c)(1)(A)(iii) (e)(1)(B) or subsection (e)(1)(C) above, whichever is less, multiplied by the hospital's average length of stay for services reimbursed under the DRG PPS.

B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B):

i) Capital related cost per diem shall be calculated in accordance with subsections (c)(1)(A)(i) through (c)(1)(A)(iii) above.

ii) Each hospital shall receive a per diem add-on for capital related costs which shall be equal to the amount calculated in subsection (c)(1)(A)(ii) or subsection (c)(1)(A)(iii) above, whichever is less.

2) Direct Medical Education Costs

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Section 149.150(c)(2) (continued)

Section 149.150(c)(2)(B) (continued)

A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A):

i)A) The direct medical education cost per diem shall be calculated by taking the hospital's inpatient direct medical education costs as reported on the hospital's latest audited Medicare cost report on file with the Department for the base period as defined in 89 Ill. Adm. Code 148.25(g)(1), divided by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national total hospital market basket price proxies (DRI).

ii)B) These two trended direct medical education costs per diem are then added together and divided by two to calculate the hospital's adjusted direct medical education cost per diem.

iii)C) The adjusted direct medical education cost per diem amount, as calculated in subsection (c)(2)(A)(ii) {e}{2}{B} above, shall be rank ordered for all hospitals reporting such costs and capped at the 80th percentile.

iv)D) Each hospital shall receive a per case add-on for direct medical education costs which shall be equal to the amount calculated in subsection (c)(2)(A)(ii) or subsection (c)(2)(A)(iii) {e}{2}{B} or subsection {e}{2}{C} above, whichever is less, multiplied by the hospital's average length of stay for services reimbursed under the DRG PPS.

B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B):

i) Effective with rate periods beginning on or after April 1, 1994, hospitals will be separated into two peer groups for the purpose of computing direct medical education cost per diems.

ii) For the purpose of computing the direct medical education cost per diem, all hospitals described in Ill. Adm. Code 148.25(d) shall be defined as major teaching hospitals. All other hospitals reporting direct medical education costs shall be defined as other teaching hospitals.

iii) Effective with rate periods beginning on or after April 1, 1994, the adjusted direct medical education cost per diem for all hospitals in each peer group shall be calculated by utilizing the direct medical education cost per diem for each hospital that were in effect on June 30, 1993, under the methodology described in subsections (c)(2)(A)(i) and (c)(2)(A)(ii) of this Section.

iv) The adjusted direct medical education cost per diem, as described in subsection (c)(2)(B)(iii) above, shall be rank ordered for all hospitals reporting such costs within each peer group, and capped at the 80th percentile.

v) Each hospital shall receive a per diem add-on for direct medical education costs which shall be equal to the amount calculated in subsection (c)(2)(B)(iii) or subsection (c)(2)(B)(iv) above, whichever is less.

3) Determination of Indirect Medical Education (IME) Adjustment Factor. To determine the indirect medical education (IME) factor, the Department shall:

A) With respect to the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), use the indirect medical education (IME) factors, as determined by HCFA, in effect on September 1, 1992. This factor shall be multiplied by the sum of the result of the calculation described in Section 149.100(c)(3) plus any applicable outlier payments as described in Section 149.105.

B) With respect to the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), use the indirect medical education (IME) factors, determined by the HCFA, in effect 90 days prior to the date of admission. This factor shall be multiplied by the sum of the result of the calculation described in Section 149.100(c)(3), plus any applicable outlier payments as described in Section 149.105.

4) CRNA Costs

A) Only hospitals that qualify for these payments under the Medicare Program effective at the beginning of each rate period, as described in 89 Ill. Adm. Code 148.25(g)(2), September 1, 1992, shall be eligible for these payments.

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Section 149.150(c)(4) (continued)

B) The CRNA cost per case amount shall be calculated by taking the hospital's total CRNA costs (as reported on the hospital's latest audited Medicare cost report on file with the Department for the base period as defined in 89 Ill. Adm. Code 148.25(g)(1)), divided by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national total hospital market basket price proxies (DRI).

C) Each qualifying hospital, as described in subsection (c)(4)(A) above, shall:

i) For the rate period described in Section 148.25(g)(2)(A), receive a per case add-on for CRNA costs which shall be equal to the amount calculated under subsection (c)(4)(B) above, multiplied by the hospital's average length of stay for services reimbursed under the DRG PPS.

ii) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), receive a per diem add-on for CRNA costs which shall be equal to the amount calculated under subsection (c)(4)(B) above.

5) Kidney Acquisition Costs. Kidney Acquisition Costs shall be reimbursed on a retrospective basis. The reimbursement shall be calculated by multiplying the hospital's total charges for the kidney acquisition by the hospital's cost-to-charge ratio as described in Section 149.105(c)(3).

6) In the event that an audited cost report is not available at the time the rates are calculated, the unaudited report for the applicable period will be used for the calculation of interim rates. Upon completion of the audit, the rate shall be recalculated. Payments made under the interim rate shall be reconciled.

6.7) A hospital wishing to appeal the calculation of its rates must notify the Department within 30 days after receipt of the rate change notification.

d) Method of Payment

1) General Rule. Unless the provisions of subsection (d)(2) apply, hospitals are paid for each discharge based on the submission of a discharge bill. Payments for inpatient hospital services

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

Section 149.150(d)(1) (continued)

furnished by an excluded distinct part psychiatric or a rehabilitation unit of a hospital are made in accordance with 89 Ill. Adm. Code 148.270(b).

2) Special Interim Payment for Unusually Long Lengths of Stay

A) First Interim Payment. A hospital may request an interim payment after a Medicaid client has been in the hospital at least 60 days. Payment for the interim bill is determined as if the bill were a final discharge bill and includes any outlier payment determined as of the last day for which services have been billed.

B) Additional Interim Payments. A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill submitted under subsection (d)(2)(A). Payment for these additional interim bills, as well as the final bill, is determined as if the bill were the final bill with appropriate adjustments made to the payment amount to reflect any previous interim payment made under the provisions of subsection (d)(2).

3) Outlier Payments. Except as provided in subsection (d)(2), payment for outlier cases (described in Section 149.105) are not made on an interim basis. The outlier payments are made based on submitted bills and represent final payment.

e) Reductions to Total Payments

1) Copayments. Copayments are assessed under all medical programs administered by the Department and shall be assessed in accordance with 89 Ill. Adm. Code 148.190.

2) Third Party Payments. Hospitals shall determine that services rendered are not covered, in whole or in part, under any other state or federal medical care program or under any other private group indemnification or insurance program, health maintenance organization, preferred provider organization, workers compensation or the tort liability of any third party. To the extent that such coverage is available, the Department's payment obligation shall be reduced.

f) Effect of Change of Ownership on Payments Under the DRG Prospective Payment System. When a hospital's ownership changes, the following rule applies: Payment for the cost of inpatient hospital services

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NOTICE OF ADOPTED AMENDMENTS

Section 149.150(f) (continued)

for each patient, including outlier payments, as provided under subsection (b) above, will be made to the entity that is the legal owner on the date of discharge. Payments will not be prorated between the buyer and seller.

- 1) The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished to a Medicaid client regardless of when the client's coverage began or ended during a stay, or of how long the stay lasted.
- 2) Each bill submitted must include all information necessary for the Department to compute the payment amount, whether or not some of the information is attributable to a period during which a different party legally owned the hospital.

(Source: Amended at 18 Ill. Reg. _____, effective February 25, 1994)

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NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Food Stamps

2) Code Citation: 89 Ill. Adm. Code 121

3) Section Numbers: Adopted Action:
121.170 Amendment
121.174 Amendment

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1991, ch. 23, pars. 12-4.4 through 12-4.6 and 12-13)[305 ILCS 5/12-4.4 through 12-4.6 and 12-13]

5) Effective Date of Amendments: February 28, 1994

6) Does this rulemaking contain an automatic repeal date? No

7) Do these Amendments contain incorporations by reference? No

8) Date Filed in Agency's Principal Office: February 28, 1994

9) Notice of Proposal Published in Illinois Register:

October 8, 1993 (17 Ill. Reg. 16405)

10) Has JCAR issued a Statement of Objections to these Adopted Amendments? No

11) Differences between proposal and final version: Based on a recommendation from the Administrative Code Division, the pending proposed citations on the notice page were completed and the main source note was brought up-to-date. No other changes were made to the text of the rule.

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes

13) Will these Amendments replace Emergency Amendments currently in effect? No

14) Are there any Amendments pending on this Part? Yes

Sections Proposed Action Illinois Register Citation

121.182	Amendment	December 27, 1993 (17 Ill. Reg. 21091)
121.182	Amendment	February 14, 1994 (18 Ill. Reg. 2178)
121.188	Amendment	December 27, 1993 (17 Ill. Reg. 21091)

15) Summary and Purpose of Amendments: These proposed amendments are necessary to specify that individuals may be assigned to Job Search for a maximum of eight weeks within a twelve consecutive month period. Limiting

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NOTICE OF ADOPTED AMENDMENTS

the Job Search component to eight weeks out of any twelve consecutive month period is required by federal regulations. These proposed amendments also increase the requirements for employer contacts from five to eight in a thirty day period in the Job Readiness component. Increasing the job contacts from five to eight in the Job Readiness component is now required by the U.S. Department of Agriculture, Food and Nutrition Services' Food Stamp program to meet the maintenance of effort criteria in the federal regulations.

16) Information and questions regarding these Adopted Amendments shall be directed to:

Name: Judy Umunna
Address: Bureau of Rules and Regulations
Illinois Department of Public Aid
100 South Grand Avenue East, Third Floor
Springfield, Illinois 62762
Telephone: (217) 524-3215

The full text of the Adopted Amendments begins on the next page:

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 121
FOOD STAMPS

SUBPART A: APPLICATION PROCEDURES

Section
121.1
121.2
121.3
121.4
121.5
121.6
121.7
121.10

Application for Assistance
Time Limitations on the Disposition of an Application
Approval of an Application and Initial Authorization of Assistance
Denial of an Application
Client Cooperation
Emergency Assistance
Expedited Services
Interviews

SUBPART B: NON-FINANCIAL FACTORS OF ELIGIBILITY

Section
121.19
121.20
121.21
121.22
121.23
121.24
121.25
121.26
121.27
121.28
121.29

Ending a Voluntary Quit Disqualification
Citizenship
Residence
Social Security Numbers
Work Registration/Participation Requirements (Repealed)
Individuals Exempt From Work Registration Requirements (Repealed)
Failure to Comply (Repealed)
Period of Disqualification (Repealed)
Voluntary Job Quit
Good Cause for Voluntary Job Quit
Exemptions from Voluntary Quit Rule

SUBPART C: FINANCIAL FACTORS OF ELIGIBILITY

Section
121.30
121.31
121.32
121.33
121.34
121.40
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121.53

Unearned Income
Exempt Unearned Income
Education Benefits
Unearned Income In-Kind
Lump Sum Payments and Income Tax Refunds
Earned Income
Budgeting Earned Income
Exempt Earned Income
Income from Work/Study/Training Programs
Earned Income from Roomer and Boarder
Income From Rental Property

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121.54 Earned Income In-Kind
121.55 Sponsors of Aliens
121.57 Assets
121.58 Exempt Assets
121.59 Asset Disregards

121.140 Small Group Living Arrangement Facilities and Drug/Alcoholic Treatment Centers

SUBPART D: ELIGIBILITY STANDARDS

SUBPART G: INTENTIONAL VIOLATIONS OF THE PROGRAM

Section

121.60 Net Monthly Income Eligibility Standards
121.61 Gross Monthly Income Eligibility Standards
121.62 Income Which Must Be Annualized
121.63 Deductions From Monthly Income
121.64 Coupon Allotment

Section

121.150 Definition of Intentional Violations of the Program
121.151 Penalties for Intentional Violations of the Program
121.152 Notification To Applicant Households
121.153 Disqualification Upon Finding of Intentional Violation of the Program
121.154 Court Imposed Disqualification

SUBPART H: FOOD STAMP EMPLOYMENT AND TRAINING PROGRAM

SUBPART E: HOUSEHOLD CONCEPT

Section

121.70 Persons Who May Be Included in the Assistance Unit
121.71 Living Arrangement
121.72 Nonhousehold Members
121.73 Ineligible Household Members
121.74 Strikers
121.75 Students
121.76 Households Receiving AFDC, SSI, Interim Assistance and/or GA - Categorical Eligibility

Section

121.160 Persons Required to Participate
121.162 Participation and Cooperation Requirements
121.164 Orientation
121.166 Assessment and Employability Plan
121.170 Job Search Component
121.172 Basic Education Component
121.174 Job Readiness Component
121.176 Work Experience Component
121.178 Job Training Component
121.180 Grant Diversion Component
121.182 Earnfare Component
121.184 Sanctions
121.186 Good Cause for Failure to Cooperate
121.188 Supportive Services
121.190 Conciliation and Fair Hearings
121.200 Types of Claims (Recodified)
121.201 Establishing a Claim for Intentional Violation of the Program (Recodified)

SUBPART F: MISCELLANEOUS PROGRAM PROVISIONS

Section

121.80 Fraud Disqualification (Renumbered)
121.81 Initiation of Administrative Fraud Hearing (Repealed)
121.82 Definition of Fraud (Renumbered)
121.83 Notification To Applicant Households (Renumbered)
121.84 Disqualification Upon Finding of Fraud (Renumbered)
121.85 Court Imposed Disqualification (Renumbered)
121.90 Monthly Reporting and Retrospective Budgeting
121.91 Monthly Reporting
121.92 Retrospective Budgeting
121.93 Direct Mail Issuance of Food Stamp Coupons
121.94 Replacement of Food Stamp Coupons
121.95 Restoration of Lost Benefits
121.96 Uses For Food Coupons
121.97 Supplemental Payments
121.98 Food Stamp Simplified Application Demonstration Project (Repealed)
121.120 Recertification of Eligibility
121.130 Residents of Shelters for Battered Women and their Children
121.135 Incorporation By Reference

121.202 Establishing a Claim for Unintentional Household Errors and Administrative Errors (Recodified)
121.203 Collecting Claim Against Households (Recodified)
121.204 Failure to Respond to Initial Demand Letter (Recodified)
121.205 Methods of Repayment of Food Stamp Claims (Recodified)
121.206 Determination of Monthly Allotment Reductions (Recodified)
121.207 Failure to Make Payment in Accordance with Repayment Schedule (Recodified)
121.208 Suspension and Termination of Claims (Recodified)

AUTHORITY: Implementing Sections 12-4.4 through 12-4.6 and authorized by Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1991, ch. 23, pars. 12-4.4 through 12-4.6 and 12-13) [305 ILCS 5/12-4.4 through 12-4.6 and 12-13]

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NOTICE OF ADOPTED AMENDMENTS

SOURCE: Adopted December 30, 1977; amended at 3 Ill. Reg. 5, p. 875, effective February 2, 1979; amended at 3 Ill. Reg. 31, p. 109, effective August 3, 1979; amended at 3 Ill. Reg. 33, p. 399, effective August 18, 1979; amended at 3 Ill. Reg. 41, p. 165, effective October 11, 1979; amended at 3 Ill. Reg. 42, p. 230, effective October 9, 1979; amended at 3 Ill. Reg. 44, p. 173, effective October 19, 1979; amended at 3 Ill. Reg. 46, p. 36, effective November 2, 1979; amended at 3 Ill. Reg. 47, p. 96, effective November 13, 1979; amended at 3 Ill. Reg. 48, p. 1, effective November 15, 1979; peremptory amendment at 4 Ill. Reg. 3, p. 49, effective January 9, 1980; peremptory amendment at 4 Ill. Reg. 9, p. 259, effective February 23, 1980; amended at 4 Ill. Reg. 10, p. 253, effective February 27, 1980; amended at 4 Ill. Reg. 12, p. 551, effective March 10, 1980; emergency amendment at 4 Ill. Reg. 29, p. 294, effective July 8, 1980, for a maximum of 150 days; amended at 4 Ill. Reg. 37, p. 797, effective September 2, 1980; amended at 4 Ill. Reg. 45, p. 134, effective October 17, 1980; amended at 5 Ill. Reg. 766, effective January 2, 1981; amended at 5 Ill. Reg. 1131, effective January 16, 1981; amended at 5 Ill. Reg. 4586, effective April 15, 1981; peremptory amendment at 5 Ill. Reg. 5722, effective June 1, 1981; amended at 5 Ill. Reg. 7071, effective June 23, 1981; peremptory amendment at 5 Ill. Reg. 10062, effective October 1, 1981; amended at 5 Ill. Reg. 10733, effective October 1, 1981; amended at 5 Ill. Reg. 12736, effective October 29, 1981; amended at 6 Ill. Reg. 1653, effective January 17, 1982; amended at 6 Ill. Reg. 2707, effective March 2, 1982; amended at 6 Ill. Reg. 8159, effective July 1, 1982; amended at 6 Ill. Reg. 10208, effective August 9, 1982; amended at 6 Ill. Reg. 11921, effective September 21, 1982; amended at 6 Ill. Reg. 12318, effective October 1, 1982; amended at 6 Ill. Reg. 13754, effective November 1, 1982; amended at 7 Ill. Reg. 394, effective January 1, 1983; codified at 7 Ill. Reg. 5195; amended at 7 Ill. Reg. 5715, effective May 1, 1983; amended at 7 Ill. Reg. 8118, effective June 24, 1983; peremptory amendment at 7 Ill. Reg. 12899, effective October 1, 1983; amended at 7 Ill. Reg. 13655, effective October 4, 1983; peremptory amendment at 7 Ill. Reg. 16067, effective November 18, 1983; amended at 7 Ill. Reg. 16169, effective November 22, 1983; amended at 8 Ill. Reg. 5673, effective April 18, 1984; amended at 8 Ill. Reg. 7249, effective May 16, 1984; peremptory amendment at 8 Ill. Reg. 10086, effective July 1, 1984; amended at 8 Ill. Reg. 13284, effective July 16, 1984; amended at 8 Ill. Reg. 17900, effective September 14, 1984; amended (by adding section being codified with no substantive change) at 8 Ill. Reg. 17898; peremptory amendment at 8 Ill. Reg. 19690, effective October 1, 1984; peremptory amendment at 8 Ill. Reg. 22145, effective November 1, 1984; amended at 9 Ill. Reg. 302, effective January 1, 1985; amended at 9 Ill. Reg. 6804, effective May 1, 1985; amended at 9 Ill. Reg. 8665, effective May 29, 1985; peremptory amendment at 9 Ill. Reg. 8898, effective July 1, 1985; amended at 9 Ill. Reg. 11334, effective July 8, 1985; amended at 9 Ill. Reg. 14334, effective September 6, 1985; peremptory amendment at 9 Ill. Reg. 15582, effective October 1, 1985; amended at 9 Ill. Reg. 16889, effective October 16, 1985; amended at 9 Ill. Reg. 19726, effective December 9, 1985; amended at 10 Ill. Reg. 229, effective December 20, 1985; peremptory amendment at 10 Ill. Reg. 7387, effective April 21, 1986; peremptory amendment at 10 Ill. Reg. 7941,

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NOTICE OF ADOPTED AMENDMENTS

effective May 1, 1986; amended at 10 Ill. Reg. 14592, effective August 29, 1986; peremptory amendment at 10 Ill. Reg. 15714, effective October 1, 1986; Sections 121.200 thru 121.208 recodified to 89 Ill. Adm. Code 165 at 10 Ill. Reg. 21094; peremptory amendment at 11 Ill. Reg. 3761, effective February 11, 1987; emergency amendment at 11 Ill. Reg. 3754, effective February 13, 1987, for a maximum of 150 days; emergency amendment at 11 Ill. Reg. 9968, effective May 15, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 10269, effective May 22, 1987; amended at 11 Ill. Reg. 10621, effective May 25, 1987; peremptory amendment at 11 Ill. Reg. 11391, effective July 1, 1987; peremptory amendment at 11 Ill. Reg. 11855, effective June 30, 1987; emergency amendment at 11 Ill. Reg. 12043, effective July 6, 1987; amended at 11 Ill. Reg. 13635, effective August 1, 1987; amended at 11 Ill. Reg. 14022, effective August 10, 1987; emergency amendment at 11 Ill. Reg. 15261, effective September 1, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 15480, effective September 4, 1987; amended at 11 Ill. Reg. 15634, effective September 11, 1987; amended at 11 Ill. Reg. 18218, effective October 30, 1987; peremptory amendment at 11 Ill. Reg. 18374, effective October 30, 1987; amended at 12 Ill. Reg. 877, effective December 30, 1987; emergency amendment at 12 Ill. Reg. 1941, effective December 31, 1987, for a maximum of 150 days; amended at 12 Ill. Reg. 4204, effective February 5, 1988; amended at 12 Ill. Reg. 9678, effective May 23, 1988; amended at 12 Ill. Reg. 9922, effective June 1, 1988; amended at 12 Ill. Reg. 11463, effective June 30, 1988; amended at 12 Ill. Reg. 12824, effective July 22, 1988; emergency amendment at 12 Ill. Reg. 14045, effective August 19, 1988, for a maximum of 150 days; peremptory amendment at 12 Ill. Reg. 15704, effective October 1, 1988; peremptory amendment at 12 Ill. Reg. 16271, effective October 1, 1988; amended at 12 Ill. Reg. 20161, effective November 30, 1988; amended at 13 Ill. Reg. 3890, effective March 10, 1989; amended at 13 Ill. Reg. 13619, effective August 14, 1989; peremptory amendment at 13 Ill. Reg. 15859, effective October 1, 1989; amended at 14 Ill. Reg. 729, effective January 1, 1990; amended at 14 Ill. Reg. 6349, effective April 13, 1990; amended at 14 Ill. Reg. 13202, effective August 6, 1990; peremptory amendment at 14 Ill. Reg. 15158, effective October 1, 1990; amended at 15 Ill. Reg. 16983, effective September 30, 1990; amended at 15 Ill. Reg. 11150, effective July 22, 1991; amended at 15 Ill. Reg. 11957, effective August 12, 1991; peremptory amendment at 15 Ill. Reg. 14134, effective October 1, 1991; emergency amendment at 16 Ill. Reg. 757, effective January 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 10011, effective June 15, 1992; amended at 16 Ill. Reg. 13900, effective August 31, 1992; emergency amendment at 16 Ill. Reg. 16221, effective October 1, 1992, for a maximum of 150 days; peremptory amendment at 16 Ill. Reg. 16345, effective October 1, 1992; amended at 16 Ill. Reg. 16624, effective October 23, 1992; amended at 17 Ill. Reg. 644, effective December 31, 1992; amended at 17 Ill. Reg. 4333, effective March 19, 1993; amended at 17 Ill. Reg. 14625, effective August 26, 1993; emergency amendment at 17 Ill. Reg. 15149, effective September 7, 1993, for a maximum of 150 days; peremptory amendment at 17 Ill. Reg. 17477, effective October 1, 1993; expedited correction at 17 Ill. Reg. 21216, effective October 1, 1993; amended at 18 Ill. Reg. 2033, effective January 21, 1994; amended at

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18 Ill. Reg. _____, effective February 28, 1994.

Section 121.174(a) (continued)

NOTE: CAPITALIZATION DENOTES STATUTORY LANGUAGE.

helps an individual gain necessary job finding skills to help find and retain employment.

SUBPART H: FOOD STAMP EMPLOYMENT AND TRAINING PROGRAM

Section 121.170 Job Search Component

a) Individuals assigned to the Job Search (JS) component based upon the employability plan must attend all scheduled meetings, including pre-arranged Job Skills Workshops conducted by other than Food Stamp Employment and Training staff. The individual will be notified in writing of all scheduled meetings. The failure of an individual to appear for scheduled meetings without good cause will constitute noncooperation.

1) The Job Readiness component is appropriate for an individual determined to be near job ready and who requires assistance to perfect job finding techniques and improve interview skills needed to obtain and to retain employment.

2) Job Readiness activities may be combined with other component activities if determined appropriate.

c) Participation Requirements

b) Individuals who fail to cooperate in Job Search without good cause shall be subject to financial sanction and/or food stamp disqualification as explained in Section 121.184.

1) Participation must be full-time unless a full-time program is not readily available or a part-time program is most appropriate based upon the individual's circumstances.

c) The individual is required to actively contact employers in his/her efforts to secure employment (i.e., mandatory registrants are required to make twenty (20) acceptable employer contacts every thirty (30) days). No individual shall receive a financial sanction and/or a food stamp disqualification for failure to make the appropriate number of job contacts, if the individual has made a good faith effort to make the job contacts (see Section 121.162(c)(2)).

2) The individual must attend all scheduled classes or sessions. The individual must make satisfactory progress based upon the written policy of the job readiness provider. If there is a job search component in the program, the individual must make up to five-(5) eight (8) acceptable employer contacts in a thirty (30) day period.

d) At the end of the Job Search period, an individual who has not found a job but has demonstrated employability will continue in Job Search. Employability is demonstrated by an individual's education, training, employment history, market factors, personal situations and experience in the Job Search component. After an individual has been placed in Job Search two consecutive times, the individual will be placed in a different component before being placed in Job Search again. Individuals may be assigned to Job Search for a maximum of eight (8) weeks within a twelve (12) consecutive month period.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 121.174 Job Readiness Component

a) An individual who has not found employment and who needs to learn the necessary essentials to obtain and maintain employment may be referred to the Job Readiness component. The Job Readiness component

DEPARTMENT OF PUBLIC AID
NOTICE OF ADOPTED AMENDMENTS

- 1) Heading of the Part: General Assistance
- 2) Code Citation: 89 Ill. Adm. Code 114
- 3) Section Numbers:
- | | |
|---------|-----------|
| 114.235 | Amendment |
| 114.241 | Amendment |
| 114.243 | Amendment |
| 114.450 | Amendment |
| 114.452 | Amendment |
| 114.454 | Amendment |
| 114.456 | Amendment |
| 114.466 | Amendment |
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1991, ch. 23, par. 12-13) [305 ILCS 5/12-13]

5) Effective Date of Amendments: February 28, 1994

6) Does this rulemaking contain an automatic repeal date? No

7) Do these Amendments contain incorporations by reference? No

8) Date Filed in Agency's Principal Office: February 28, 1994

9) Notice of Proposal Published in Illinois Register:

November 12, 1993 (17 Ill. Reg. 19443)

10) Has JCAR issued a Statement of Objections to these Adopted Amendments? No

11) Differences between proposal and final version: Based on a recommendation from the Administrative Code Division, in Section 114.454(b)(1), the language from "family" to "household" was capitalized to denote statutory language. In addition, the language in Section 114.454(c) was capitalized to denote statutory language. No other changes were made to this rulemaking.

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes

13) Will these Amendments replace Emergency Amendments currently in effect? No

14) Are there any Amendments pending on this Part? Yes

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NOTICE OF ADOPTED AMENDMENTS

Sections	Proposed Action	Illinois Register Citation
114.351	Amendment	December 31, 1993 (17 Ill. Reg. 22308)
114.352	Amendment	December 31, 1993 (17 Ill. Reg. 22308)
114.353	Amendment	December 31, 1993 (17 Ill. Reg. 22308)

15) Summary and Purpose of Amendments: These proposed amendments are needed to enable the Department to provide direct payment for child care expenses for family GA cases to qualified child care providers, except for certain exceptions. As a result of these proposed amendments child care expenses will only be deductible as an employment expense for cases that are exceptions to direct payment. These proposed amendments also provide that direct payment and the child care deduction will not be allowed when the child care provider is a responsible relative of the child receiving care.

16) Information and questions regarding these Adopted Amendments shall be directed to:

Name: Judy Umunna
Address: Bureau of Rules and Regulations
Illinois Department of Public Aid
100 South Grand Avenue East, Third Floor
Springfield, Illinois 62762
Telephone: (217) 524-3215

The full text of the Adopted Amendments begins on the next page:

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 114
GENERAL ASSISTANCE

SUBPART A: GENERAL PROVISIONS

Section
114.1
114.2
114.5

Description of the Assistance Program
Determination of Not Employable
Incorporation By Reference

SUBPART B: NON-FINANCIAL FACTORS OF ELIGIBILITY

Section
114.9
114.10
114.20
114.30
114.40
114.50
114.52
114.60
114.61

Client Cooperation
Citizenship
Residence
Age
Relationship
Living Arrangement
Social Security Numbers
Work Registration Requirements (Outside City of Chicago only)
Individuals Exempt From Work Registration Requirements (Outside City of Chicago only)
City of Chicago only
Job Service Registration (Outside City of Chicago only)
Failure to Maintain Current Job Service Registration (Outside City of Chicago only)
Responsibility to Seek Employment (Outside City of Chicago only)
Initial Employment Expenses (Outside City of Chicago only)
Downstate General Assistance Work and Training Programs
Downstate General Assistance - Food Stamps Employment and Training Pilot Project
Project Chance Participation/Cooperation Requirements (Renumbered)
General Assistance Jobs Program (Repealed)

SUBPART C: PROJECT ADVANCE

Section
114.108
114.109
114.110
114.111
114.113
114.115
114.117

Project Advance
Project Advance Participation Requirements of Adjudicated Fathers
Project Advance Cooperation Requirements of Adjudicated Fathers
Project Advance Sanctions
Project Advance Good Cause for Failure to Comply
Individuals Exempt From Project Advance
Project Advance Supportive Services

DEPARTMENT OF PUBLIC AID

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SUBPART D: EMPLOYMENT AND TRAINING REQUIREMENTS

Section
114.120
114.121
114.122

Employment and Training Requirements
Persons Required to Participate in Project Chance (Repealed)
Advocacy Program for Persons Who Have Applied for Supplemental Security Income (SSI) Under Title XVI of the Social Security Act (Repealed)
Persons in Need of Work Rehabilitative Services (WRS) to Become Employable (Repealed)
Employment and Training Participation/Cooperation Requirements (Repealed)

114.125
114.126

Employment and Training Program Orientation (Repealed)
Employment and Training Program Full Assessment Process/Development of an Employment Plan (Repealed)

114.127
114.128
114.129

Employment and Training Program Components (Repealed)
Employment and Training Sanctions (Repealed)
Good Cause For Failure to Cooperate With Work and Training Participation Requirements (Repealed)

114.130
114.135
114.140

Employment and Training Supportive Services (Repealed)
Conciliation and Fair Hearings (Repealed)
Employment Child Care (Repealed)

SUBPART E: FINANCIAL FACTORS OF ELIGIBILITY

Section
114.200
114.201
114.202

Unearned Income
Budgeting Unearned Income
Budgeting Unearned Income of Applicants Receiving Income On Date of Application And/Or Date of Decision

114.203
114.204
114.210
114.220
114.221

Initial Receipt of Unearned Income
Termination of Unearned Income
Exempt Unearned Income
Education Benefits
Unearned Income In-Kind

114.222
114.223
114.224
114.225
114.226
114.227

Unmarked Income
Lump Sum Payments
Protected Income
Earned Income
Budgeting Earned Income
Budgeting Earned Income of Applicants Receiving Income On Date of Application And/Or Date of Decision

114.228
114.229
114.230
114.235
114.240
114.241

Initial Employment
Termination of Employment
Exempt Earned Income
Recognized Employment Expenses
Income From Work/Study/Training Program (Repealed)
Earned Income From Self-Employment

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114.242 Earned Income From Roomer and Boarder
 114.243 Earned Income From Rental Property
 114.244 Earned Income In-Kind
 114.245 Payments from the Illinois Department of Children and Family Services

114.246 Budgeting Earned Income For Contractual Employees
 114.247 Budgeting Earned Income For Non-contractual School Employees
 114.250 Assets
 114.251 Exempt Assets
 114.252 Asset Disregards
 114.260 Deferral of Consideration of Assets (Repealed)
 114.270 Property Transfers (Repealed)
 114.280 Supplemental Payments

SUBPART F: PAYMENT AMOUNTS

Section
 114.350 Payment Levels for General Assistance
 114.351 Payment Levels in Group I Counties
 114.352 Payment Levels in Group II Counties
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SUBPART G: OTHER PROVISIONS

Section
 114.400 Persons Who May Be Included In the Assistance Unit
 114.401 Eligibility of Strikers
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 114.403 Institutional Status
 114.404 Retrospective Budgeting
 114.405 Budgeting Schedule
 114.406 Limitation on Amount of General Assistance to Recipients from Other States

114.420 Redetermination of Eligibility
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SUBPART H: CHILD CARE

Section
 114.450 Child Care
 114.452 Child Care Eligibility
 114.454 Qualified Provider
 114.456 Notification of Available Services
 114.458 Participant Rights and Responsibilities
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114.456 Method of Providing Child Care
 SUBPART I: TRANSITIONAL CHILD CARE

Section
 114.500 Transitional Child Care Eligibility
 114.504 Duration of Eligibility for Transitional Child Care
 114.506 Loss of Eligibility for Transitional Child Care
 114.508 Qualified Provider
 114.510 Notification of Available Services
 114.512 Participant Rights and Responsibilities
 114.514 Child Care Overpayments and Recoveries
 114.516 Fees for Service for Transitional Child Care
 114.518 Rates of Payment for Transitional Child Care

AUTHORITY: Implementing Article VI and authorized by Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1991, ch. 23, pars. 6-1 et seq. and 12-13) [305 ILCS 5/Art. 6-1 et seq. and 5/12-13]

SOURCE: Filed effective December 30, 1977; peremptory amendment at 2 Ill. Reg. 17, p. 117, effective February 1, 1978; amended at 2 Ill. Reg. 31, p. 134, effective August 5, 1978; emergency amendment at 2 Ill. Reg. 37, p. 4, effective August 30, 1978, for a maximum of 150 days; peremptory amendment at 2 Ill. Reg. 46, p. 44, effective November 1, 1978; peremptory amendment at 2 Ill. Reg. 46, p. 56, effective November 1, 1978; emergency amendment at 3 Ill. Reg. 16, p. 41, effective April 9, 1979, for a maximum of 150 days; emergency amendment at 3 Ill. Reg. 28, p. 182, effective July 1, 1979, for a maximum of 150 days; amended at 3 Ill. Reg. 33, p. 399, effective August 18, 1979; amendment at 3 Ill. Reg. 33, p. 415, effective August 18, 1979; amended at 3 Ill. Reg. 38, p. 243, effective September 21, 1979; peremptory amendment at 3 Ill. Reg. 38, p. 321, effective September 7, 1979; amended at 3 Ill. Reg. 40, p. 140, effective October 6, 1979; amended at 3 Ill. Reg. 46, p. 36, effective November 2, 1979; amended at 3 Ill. Reg. 47, p. 96, effective November 13, 1979; amended at 3 Ill. Reg. 48, p. 1, effective November 15, 1979; peremptory amendment at 4 Ill. Reg. 9, p. 259, effective February 22, 1980; amended at 4 Ill. Reg. 10, p. 258, effective February 25, 1980; amended at 4 Ill. Reg. 12, p. 551, effective March 10, 1980; amended at 4 Ill. Reg. 27, p. 387, effective June 24, 1980; emergency amendment at 4 Ill. Reg. 29, p. 294, effective July 8, 1980, for a maximum of 150 days; amended at 4 Ill. Reg. 37, p. 797, effective September 2, 1980; amended at 4 Ill. Reg. 37, p. 800, effective September 2, 1980; amended at 4 Ill. Reg. 45, p. 134, effective October 27, 1980; amended at 5 Ill. Reg. 766, effective January 2, 1981; amended at 5 Ill. Reg. 1134, effective January 26, 1981; peremptory amendment at 5 Ill. Reg. 5722, effective June 1, 1981; amended at 5 Ill. Reg. 7071, effective June 23, 1981; amended at 5 Ill. Reg. 7104, effective June 23, 1981; amended at 5 Ill. Reg. 8041, effective July 27, 1981; amended at 5 Ill. Reg. 8052, effective July 24, 1981; peremptory amendment at 5 Ill. Reg. 8106, effective August 1, 1981; peremptory amendment at 5 Ill. Reg. 10062, effective October 1, 1981;

peremptory amendment at 5 Ill. Reg. 10079, effective October 1, 1981;
 peremptory amendment at 5 Ill. Reg. 10095, effective October 1, 1981;
 peremptory amendment at 5 Ill. Reg. 10113, effective October 1, 1981;
 peremptory amendment at 5 Ill. Reg. 10124, effective October 1, 1981;
 peremptory amendment at 5 Ill. Reg. 10131, effective October 1, 1981; amended
 at 5 Ill. Reg. 10730, effective October 1, 1981; amended at 5 Ill. Reg. 10733,
 effective October 1, 1981; amended at 5 Ill. Reg. 10760, effective October 1,
 1981; amended at 5 Ill. Reg. 10767, effective October 1, 1981; peremptory
 amendment at 5 Ill. Reg. 11647, effective October 16, 1981; peremptory
 amendment at 6 Ill. Reg. 611, effective January 1, 1982; amended at 6 Ill.
 Reg. 1216, effective January 14, 1982; emergency amendment at 6 Ill. Reg.
 2447, effective March 1, 1982, for a maximum of 150 days; peremptory amendment
 at 6 Ill. Reg. 2452, effective February 11, 1982; peremptory amendment at 6
 Ill. Reg. 6475, effective May 18, 1982; peremptory amendment at 6 Ill. Reg.
 6912, effective May 20, 1982; emergency amendment at 6 Ill. Reg. 7299,
 effective June 2, 1982, for a maximum of 150 days; amended at 6 Ill. Reg.
 8115, effective July 1, 1982; amended at 6 Ill. Reg. 8142, effective July 1,
 1982; amended at 6 Ill. Reg. 8159, effective July 1, 1982; amended at 6 Ill.
 Reg. 10970, effective August 26, 1982; amended at 6 Ill. Reg. 11921, effective
 September 21, 1982; amended at 6 Ill. Reg. 12293, effective October 1, 1982;
 amended at 6 Ill. Reg. 12318, effective October 1, 1982; amended at 6 Ill.
 Reg. 13754, effective November 1, 1982; rules repealed, new rules adopted and
 codified at 7 Ill. Reg. 907, effective January 7, 1983; amended (by adding
 Sections being codified with no substantive change) at 7 Ill. Reg. 5195;
 amended at 7 Ill. Reg. 9009, effective August 5, 1983; amended (by adding
 section being codified with no substantive change) at 7 Ill. Reg. 14747;
 amended (by adding section being codified with no substantive change) at 7
 Ill. Reg. 16107; amended at 7 Ill. Reg. 16408, effective November 30, 1983;
 amended at 7 Ill. Reg. 16652, effective December 1, 1983; amended at 8 Ill.
 Reg. 243, effective December 27, 1983; amended at 8 Ill. Reg. 5233, effective
 April 9, 1984; amended at 8 Ill. Reg. 6764, effective April 27, 1984; amended
 at 8 Ill. Reg. 11435, effective June 27, 1984; amended at 8 Ill. Reg. 13319,
 effective July 16, 1984; amended at 8 Ill. Reg. 16237, effective August 24,
 1984; amended (by adding sections being codified with no substantive change)
 at 8 Ill. Reg. 17896; amended at 9 Ill. Reg. 314, effective January 1, 1985;
 emergency amendment at 9 Ill. Reg. 823, effective January 3, 1985, for a
 maximum of 150 days; amended at 9 Ill. Reg. 9557, effective June 5, 1985;
 amended at 9 Ill. Reg. 10764, effective July 5, 1985; amended at 9 Ill. Reg.
 15800, effective October 16, 1985; amended at 10 Ill. Reg. 1924, effective
 January 17, 1986; amended at 10 Ill. Reg. 3660, effective January 30, 1986;
 emergency amendment at 10 Ill. Reg. 4646, effective February 3, 1986, for a
 maximum of 150 days; amended at 10 Ill. Reg. 4896, effective March 7, 1986;
 amended at 10 Ill. Reg. 10681, effective June 3, 1986; amended at 10 Ill. Reg.
 11041, effective June 5, 1986; amended at 10 Ill. Reg. 12662, effective July
 14, 1986; amended at 10 Ill. Reg. 15118, effective September 5, 1986; amended
 at 10 Ill. Reg. 15640, effective September 19, 1986; amended at 10 Ill. Reg.
 19079, effective October 24, 1986; amended at 11 Ill. Reg. 2307, effective
 January 16, 1987; amended at 11 Ill. Reg. 5297, effective March 11, 1987;

amended at 11 Ill. Reg. 6238, effective March 20, 1987; emergency amendment at
 11 Ill. Reg. 12449, effective July 10, 1987, for a maximum of 150 days;
 emergency amendment at 11 Ill. Reg. 12948, effective August 1, 1987, for a
 maximum of 150 days; emergency amendment at 11 Ill. Reg. 18311, effective
 November 1, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 18689,
 effective November 1, 1987; emergency amendment at 11 Ill. Reg. 18791,
 effective November 1, 1987, for a maximum of 150 days; amended at 11 Ill. Reg.
 20129, effective December 4, 1987; amended at 11 Ill. Reg. 20889, effective
 December 14, 1987; amended at 12 Ill. Reg. 889, effective January 1, 1988;
 SUBPARTS C, D and E recodified to SUBPARTS E, F and G at 12 Ill. Reg. 2147;
 Section 114.110 recodified to Section 114.52 at 12 Ill. Reg. 2984; amended at
 12 Ill. Reg. 3505, effective January 22, 1988; amended at 12 Ill. Reg. 6170,
 effective March 18, 1988; amended at 12 Ill. Reg. 6719, effective March 22,
 1988; amended at 12 Ill. Reg. 9108, effective May 20, 1988; amended at 12 Ill.
 Reg. 9699, effective May 24, 1988; amended at 12 Ill. Reg. 9940, effective May
 31, 1988; amended at 12 Ill. Reg. 11474, effective June 30, 1988; amended at
 12 Ill. Reg. 14255, effective August 30, 1988; emergency amendment at 12 Ill.
 Reg. 14364, effective September 1, 1988, for a maximum of 150 days; amended at
 12 Ill. Reg. 16729, effective September 30, 1988; amended at 12 Ill. Reg.
 20171, effective November 28, 1988; amended at 13 Ill. Reg. 89, effective
 January 1, 1989; amended at 13 Ill. Reg. 1546, effective January 20, 1989;
 amended at 13 Ill. Reg. 3900, effective March 10, 1989; amended at 13 Ill.
 Reg. 8580, effective May 20, 1989; emergency amendment at 13 Ill. Reg. 16169,
 effective October 2, 1989, for a maximum of 150 days; emergency expired March
 1, 1990; amended at 13 Ill. Reg. 16015, effective October 6, 1989; amended at
 14 Ill. Reg. 746, effective January 1, 1990; amended at 14 Ill. Reg. 3640,
 effective February 23, 1990; amended at 14 Ill. Reg. 6360, effective April 16,
 1990; amended at 14 Ill. Reg. 10929, effective June 20, 1990; amended at 14
 Ill. Reg. 13215, effective August 6, 1990; amended at 14 Ill. Reg. 13777,
 effective August 10, 1990; amended at 14 Ill. Reg. 14162, effective August 17,
 1990; amended at 14 Ill. Reg. 17111, effective September 30, 1990; amended at
 15 Ill. Reg. 288, effective January 1, 1991; amended at 15 Ill. Reg. 5710,
 effective April 10, 1991; amended at 15 Ill. Reg. 11164, effective August 1,
 1991; emergency amendment at 15 Ill. Reg. 15144, effective October 7, 1991,
 for a maximum of 150 days; amended at 16 Ill. Reg. 3512, effective February
 20, 1992; emergency amendment at 16 Ill. Reg. 4540, effective March 10, 1992,
 for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 11662,
 effective July 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg.
 13297, effective August 15, 1992; emergency amendment at 16 Ill. Reg. 13651,
 effective September 1, 1992, for a maximum of 150 days; emergency amendment at
 16 Ill. Reg. 14769, effective September 15, 1992, for a maximum of 150 days;
 emergency amendment at 16 Ill. Reg. 16276, effective October 1, 1992, for a
 maximum of 150 days; emergency amendment at 16 Ill. Reg. 17772, effective
 November 13, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 18815,
 effective November 24, 1992; amended at 17 Ill. Reg. 1091, effective January
 15, 1993; amended at 17 Ill. Reg. 2277, effective February 15, 1993; amended
 at 17 Ill. Reg. 3639, effective February 26, 1993; amended at 17 Ill. Reg.
 3255, effective March 1, 1993; amended at 17 Ill. Reg. 6814, effective April

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21, 1993; emergency amendment at 17 Ill. Reg. 19728, effective November 1, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. _____, effective February 28, 1994.

NOTE: CAPITALIZATION DENOTES STATUTORY LANGUAGE

SUBPART E: FINANCIAL FACTORS OF ELIGIBILITY

Section 114.235 Recognized Employment Expenses

- a) For earnings from self-employment and rental property, an amount equal to the expenses directly attributable to producing goods or services or an amount equal to the expenses of rental shall be deducted from income.
- b) For employment expenses, \$90.00 shall be deducted from the gross earned income of each employed individual.

c) Child Care

- 1) Child care expenses for children under the age of 13 are to be covered as direct payment. Children age 13 and over may be covered by direct payment if they are physically or mentally incapable of self-care or under court supervision. A statement from a physician or certified psychologist or copy of the court order is required. Expenses of child care shall be deducted from income up to a maximum of \$200.00 per child for each child under the age of two (2) and \$175.00 for each child age two (2) and over.

- 2) Direct payment is not allowed when the child care provider is a responsible relative of the child receiving care as defined in 89 Ill. Adm. Code 103.10(b). The child care deduction is not allowed when the child care provider is a responsible relative (see 89 Ill. Adm. Code 103.10(b)) of the child receiving care.

- 3) Direct payment for child care expenses shall be made to qualified child care providers in accordance with Section 114.454.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 114.241 Earned Income From Self-Employment

- a) Income realized from self-employment shall be considered earned income.

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Section 114.241 (continued)

- b) Accurate and complete records shall be kept on all monies received and spent through self-employment. If the individual fails or refuses to maintain complete business records, the assistance unit shall be ineligible.
- c) Business expenses shall be verified. The individual shall have full responsibility for proof of any business expense. No deduction shall be allowed for depreciation, obsolescence or any and/or similar losses in the operation of the business. Gross income from the business shall be turned back into the business only to replace stock actually sold.
- d) The net income shall be the gross remaining after the replacement of stock and business expenses have been considered, and the \$90.00 appropriate employment expenses and child-care expenses, as specified in Section 114.235, have been deducted. No deduction for child care expenses is allowed.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 114.243 Earned Income From Rental Property

- a) Income which a client receives from rental property which he owns shall be considered earned income if the client is actively engaged in the management of the property for an average (as determined by looking at the term of the certification period) of at least 20 hours per week.
- b) When determining net income, the reasonable and necessary rental expenses which the client incurs in the production of income may be deducted from the gross income. Reasonable and necessary rental expenses include repairs, taxes, insurance, and utilities if the landlord pays them.
- c) If a client is responsible for cleaning a room and providing clean linens, the income which he receives shall be considered earned income from a roomer rather than earned income from rental property.
- d) After deduction of rental expenses, the appropriate employment expenses, and child-care expenses, as specified in Section 114.235, shall be deducted to determine net rental income. No deduction for child care expenses is allowed.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

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SUBPART H: CHILD CARE

Section 114.450 Child Care

- a) This Subpart refers only to family cases as defined at 89 Ill. Adm. Code 101.20.
- b) The Department will guarantee child care for children as described in Section 114.235(c)(1):
 - 1) for each family case requiring such care, to the extent that such care is determined by the Department to be necessary for an individual in the family to accept employment or remain employed; and
 - 2) for each individual participating in activities provided in Sections 114.124, 114.125, 114.126 and 114.127 including participation in ancillary support services or activities, such as life skills training, or substance abuse treatment, etc., if the Department has approved the activity (in accordance with Section 114.126) and has determined that the individual is satisfactorily participating (as defined at Section 114.127) in the activity.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 114.452 Child Care Eligibility

- a) Child care will be provided for a dependent child as described in Section 114.235(c)(1) of a person receiving General Assistance to allow such individual to participate in education or training and for employment.
- b) Eligibility is also extended to children who meet the criteria in subsection (a) who would be dependent except for benefits under Supplemental Security Income under Title XVI of the Social Security Act (42 U.S.C. 1381 et seq.) or foster care under Title IV-E of the Social Security Act (42 U.S.C. 670 et. seq.) and the caretaker relative is also a member of a household receiving General Assistance.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 114.454 Qualified Provider

Payment will be made for child care that otherwise meets the requirements of this Subpart and meets applicable standards of State and local law and regulation, including but not limited to licensure requirements promulgated by

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Section 114.454 (continued)

the Department of Children and Family Services (DCFS) at 89 Ill. Adm. Code: Chapter I, Subchapter (e), and Fire Prevention and Safety requirements promulgated by the Office of the State Fire Marshal at 41 Ill. Adm. Code 100, and is provided in any of the following:

- a) Day Care Center
 - 1) A day care center licensed by DCFS which regularly provides child care for less than twenty-four (24) hours per day:
 - A) for more than eight (8) children in a family home, or
 - B) for more than three (3) children in a facility other than a family home.
- 2) A day care center exempt from licensure pursuant to Section 2.09 of the Child Care Act of 1969 (Ill. Rev. Stat. 1991 1989, ch. 23, par. 2212.09) [225 ILCS 10/2.09].
- b) Licensed Day Care Home or License-Exempt Home
 - 1) A licensed day care home is any family home which provides child care for less than twenty-four (24) hours per day, and for more than three (3) children up to a maximum of eight (8) children. The maximum of eight (8) children includes the family's natural or adopted children and all persons under the age of twelve (12). A licensed day care home does not include a home which provides child care to only children from the same household. FAMILY HOME WHICH PROVIDES CHILD CARE FOR LESS THAN 24 HOURS PER DAY, AND FOR MORE THAN THREE CHILDREN UP TO A MAXIMUM OF 12 CHILDREN. THE MAXIMUM OF 12 CHILDREN INCLUDES THE FAMILY'S NATURAL OR ADOPTED CHILDREN AND ALL PERSONS UNDER THE AGE OF 12. A LICENSED DAY CARE HOME DOES NOT INCLUDE A HOME WHICH PROVIDES CHILD CARE TO ONLY CHILDREN FROM THE SAME HOUSEHOLD. (Section 2.18 of the Child Care Act of 1969 (Ill. Rev. Stat. 1991 1989, ch. 23, par. 2212.18) [225 ILCS 20/2.18]).
 - 2) A home exempt from licensing is a home in which no more than three unrelated children under the age of twelve (12) years, including the children of the provider, are cared for at one time. This home is not subject to licensing by DCFS.
- c) Licensed Group Day Care Home

A licensed group day care home is a home where no more than twelve (12) unrelated children, including the children of the provider,

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Section 114.454(c) (continued)

~~under the age of twelve (12) are cared for home where no more than 16 UNRELATED CHILDREN, INCLUDING THE CHILDREN OF THE PROVIDERS, UNDER THE AGE OF 12 ARE CARED FOR (Section 2.20 of the Child Care Act of 1969 (Ill. Rev. Stat. 1991, ch. 23, par. 2212.20) [225 ILCS 10/2.20]).~~

d) Relatives and Babysitters

- 1) Care provided by a relative in his or her home or in the child's home. Relatives living in the same home as the child are eligible for payment with the exception of the child's mother or father or a person in the same assistance grant as the child.
- 2) Care provided by a non-relative in the child's home provided the non-relative is not in the same assistance grant as the child.

e) ~~The provisions of this Section are not applicable to families using the child-care disregard (as provided at Section 114.235 pursuant to Section 114.366).~~

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 114.456 Notification of Available Services

a) The Department will notify all applicants and families receiving General Assistance in writing and orally of programs and supportive services available to them for which they are eligible, and the rights, responsibilities and obligations of participants in the program.

b) The Department will respond to a request for child care within ~~forty-five (45)~~ days from the date the request is received by the ~~Department in the local Public Aid Office.~~

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 114.466 Method of Providing Child Care

Child care may be provided through one of the following methods:

- a) arranging the child care through eligible providers by use of purchase of service contracts or vouchers;
- b) arranging with other agencies and community volunteer groups for non-reimbursed child care; or

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Section 114.466 (continued)

- c) ~~using the child-care disregard as provided in Section 114.235, or~~
- d) adopting such other arrangements as the Department determines appropriate which facilitate service delivery and do not disadvantage the family receiving the service.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

1) Heading of the Part: Hospital Services

2) Code Citation: 89 Ill. Adm. Code 148

3) Section Numbers: Adopted Action:

- 148.20, 148.25, 148.40, Amendment
- 148.50, 148.60, 148.70, Amendment
- 148.82, 148.120, 148.130 Amendment
- 148.140, 148.150, 148.160 Amendment
- 148.170, 148.180, 148.200 Amendment
- 148.210, 148.230, 148.240 Amendment
- 148.250, 148.260, 148.270 Amendment
- 148.280, 148.290, 148.310 Amendment

4) Statutory Authority: Articles III, IV, V, VI, VII and Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1991, ch. 23, pars. 3-1 et seq., 4-1 et seq., 5-1 et seq., 6-1 et seq., 7-1 et seq., and 12-13), [305 ILCS 5/Arts. 3, 4, 5, 6, 7, and 5/12-13] Public Act 87-861, effective July 8, 1992, Public Act 88-85, effective July 14, 1993, and Public Act 88-88, effective July 14, 1993.

5) Effective Date of Amendments: February 28, 1994

6) Does this rulemaking contain an automatic repeal date? No

7) Do these Amendments contain incorporations by reference? No

8) Date Filed in Agency's Principal Office: February 28, 1994

9) Notice of Proposal Published in Illinois Register:

September 24, 1993 (17 Ill. Reg. 15291)

10) Has JCAR issued a Statement of Objections to these Adopted Amendments? No

11) Differences between proposal and final version: The following changes have been made in the proposed amendments.

Section 148.25

Subsection (b)(1)(A) has been revised to read:

- A) County-owned hospitals, shall mean all county-owned hospitals, that are located in an Illinois county with a population of over 3 million.

Subsection (b)(1)(B) has been revised to read:

B) A hospital and/or hospitals organized under the University of Illinois Hospital Act.

Subsection (b)(2)(B) has been deleted.

Subsection (b)(2)(C) has been renumbered to subsection (b)(2)(B) and has been revised to read:

B) A hospital and/or hospitals organized under the University of Illinois Hospital Act.

Subsection (b)(2)(D) has been renumbered to subsection (b)(2)(C).

Section 148.50

Subsection (c)(2)(B)(iii) has been revised to read:

iii) Reimbursement is limited to services provided after the minimum number of contracts have been made. Reimbursement will not be made for services which were billed as acute inpatient care and denied as not being medically necessary. Reimbursement will be made for up to a maximum of 31 days before additional documentation must be submitted to extend the eligibility for additional reimbursement.

Section 148.120

Subsection (c)(3)(D) has been revised to read:

(D) Hospital Residing Long Term Care Days. The Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of hospital residing long term care days provided to recipients.

Subsection (g)(2)(B) has been revised to read:

(B) For county-owned hospitals, as described in Section 148.25(b)(1)(A), or a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), the amount calculated pursuant to subsection (g)(2)(A) above shall be increased by \$60 per day.

Subsection (g)(2)(C) has been revised to read:

(C) The Medicaid percentage adjustment payment, calculated in accordance with this subsection (g)(2), to a hospital, other than county-owned hospitals, as described in Section

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148.25(b)(1)(A), or a hospital and/or hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), shall not exceed \$155 per day for a children's hospital, as described in subsection (a)(5) of this Section, and shall not exceed \$215 per day for all other hospitals.

Subsection (h) has been revised to read:

- h) Inpatient Adjustor for Children's Hospitals. For a children's hospital, as defined in subsection (a)(5) of this Section, the payment adjustment calculated under subsection (g)(2) above shall be multiplied by 2.0.

Subsection (i) has been revised to read:

- i) Inpatient Adjustor for County-Owned Hospitals. For county-owned hospitals, as defined in Section 148.25(b)(1)(A), the payment adjustment calculated under subsection (g)(2) above shall be multiplied by 3.75.

Subsection (j) has been revised to read:

- j) Inpatient Adjustor for Hospitals Organized Under the University of Illinois Hospital Act. For a hospital and/or hospitals organized under the University of Illinois Hospital Act, as defined in Section 148.25(b)(1)(B), the payment adjustment calculated under subsection (g)(2) above shall be multiplied by 3.75.

Section 148.140

In subsection (a)(1)(A), the reference to "subsection (b)(1)" has been changed to "subsection (b); and the reference to "subsection (d)(7)(B)" has been changed to "subsection (b)(7)".

In Subsection (a)(1)(B), the reference to "subsection (d)(7)(B)" has been changed to "subsection (c)(5); and the word "and" has been added immediately after the ";".

Subsection (a)(1)(C) has been deleted in its entirety.

Subsection (a)(1)(D) has been renumbered as subsection (a)(1)(C).

Subsection (a)(3) has been revised to read:

- 3) With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rate described in subsection (a)(2) above shall be adjusted on a retrospective basis. The

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retrospective adjustment shall be calculated as follows:

A new subsection (a)(3)(A) has been added to read:

- A) The reimbursement rates described in subsection (a)(2) above shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.

A new subsection (a)(3)(B) has been added to read:

- B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

In subsection (a)(4), the language "for covered services, as described in 89 Ill. Adm. Code 140.462(e)(3)," has been added immediately before the language "that are provided to non-assigned Healthy Moms/Healthy Kids program clients, as described in 89 Ill. Adm. Code 140.464(b)(1)."

In subsection (a)(5), reference to "Section 148.25(b)(5)(D)" has been corrected to "Section 148.25(b)(5)(D)".

A new subsection (a)(6) has been added to read:

- 6) Hospitals described in Sections 148.25(b)(2)(A) and 148.25(b)(2)(B), shall be required to submit outpatient cost reports to the Department within 90 days of the close of the facility's fiscal year.

A new subsection (a)(7) has been added to read:

- 7) With the exception of the retrospective adjustment described in subsection (a)(3) above, no year-end reconciliation is made to the reimbursement rates calculated under this Section.

In subsection (b)(1)(D), the words "high risk," have been deleted.

In subsection (b)(3), the word "physical" has been added immediately before the words "rehabilitation clinic department".

In subsection (b)(4)(B)(i), the language ", or a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3)" has been added immediately before the ";".

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In subsection (b)(4)(C)(i), the language ", or a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3)" has been added immediately before the ";".

In subsection (b)(4)(D)(i), the language ", or a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3)" has been added immediately before the ";".

In subsection (b)(4)(D)(iii), the word "physical" has been added immediately before the words "rehabilitation clinic department".

In subsection (b)(5) change reference "148.25(b)(2)(B)" to read "148.25(b)(2)(C)" and delete references "148.25(b)(2)(D)" and "148.25(b)(5)(B)".

A new subsection (b)(5)(C)(i) has been added to read:

- i) As a condition of eligibility for an outpatient indigent volume adjustment for outpatient services provided on or after October 1, 1993, and on or before December 31, 1993, hospitals that did not comply with the data requirement described in Section 148.150(c) shall be required to submit, on or before October 1, 1993, the data required under Section 148.150(d).

A new subsection (b)(5)(C)(ii) has been added to read:

- ii) Subject to the provisions of subsection (b)(5)(C)(iii) below, a hospital that did not comply with the requirements of subsection (b)(5)(C)(i) above on or before October 1, 1993, shall not be eligible for outpatient indigent volume adjustments for outpatient services provided on or after October 1, 1993, and on or before September 30, 1994.

A new subsection (b)(5)(C)(iii) has been added to read:

- iii) Notwithstanding the provisions of subsection (b)(5)(C)(ii) above, a hospital that has failed to comply with the requirements of subsection (b)(5)(C)(i) above on or before October 1, 1993, but does comply with such requirements on or before November 5, 1993, shall be ineligible for outpatient indigent volume adjustments for outpatient services provided on or after October 1, 1993, and on or before December 31, 1993, but shall be eligible for outpatient indigent volume adjustments for outpatient services provided on or after January 1, 1994, and on or before September 30, 1994.

A new subsection (b)(5)(C)(iv) has been added to read:

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- iv) Effective with outpatient services provided on or after October 1, 1994, as a condition of eligibility for outpatient indigent volume adjustments, hospitals that did not comply with the data requirement described in Section 148.150(c) shall be required to submit, by the first day of October of each year, the data described in 148.150(c) in addition to the data required under 148.150(d). A hospital that does not comply with these data requirements by the first day of October of each year shall be ineligible for outpatient indigent volume adjustments for the rate period.

A new subsection (b)(5)(D)(iii) has been added to read:

- iii) "Rate period" means, for dates of service on or after October 1, 1993, the twelve month period beginning on October 1 of the year and ending on September 30 of the following year.

Subsection (b)(5)(D)(iii) has been renumbered to subsection (b)(5)(D)(iv).

Subsection (b)(5)(D)(iv) has been renumbered to subsection (b)(5)(D)(v).

Subsection (b)(6) has been revised to read:

- 6) No Year-End Reconciliation

With the exception of the retrospective rate adjustment described in subsection (b)(7) of this Section, no year-end reconciliation is made to the reimbursement rates calculated under this subsection (b).

Subsection (b)(7) has been revised to read:

- 7) Rate Adjustments

With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rates described in subsection (b)(4) above shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:

A new subsection (b)(7)(A) has been added to read:

- A) The reimbursement rates described in subsection (b)(4) above shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.

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A new subsection (b)(7)(B) has been added to read:

- B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

A new subsection (b)(9) has been added to read:

- 9) Hospitals described in Sections 148.25(b)(2)(A) and (b)(2)(B) shall be required to submit outpatient cost reports to the Department within 90 days of the close of the facility's fiscal year.

A new subsection (c)(5) has been added to read:

- 5) With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rates described in this subsection (c) shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:

A new subsection (c)(5)(A) has been added to read:

- A) The reimbursement rates described in this subsection (c) shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.

A new subsection (c)(5)(B) has been added to read:

- B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

A new subsection (c)(6) has been added to read:

- 6) With the exception of the retrospective rate adjustment described in subsection (c)(5) above, no year-end reconciliation is made to the reimbursement rates calculated under this subsection (c).

A new subsection (c)(7) has been added to read:

- 7) Hospitals described in Sections 148.25(b)(2)(A) and 148.25(b)(2)(B) shall be required to submit outpatient cost reports to the Department within 90 days of the close of the facility's fiscal year.

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The title of subsection (d) has been changed from "Encounter Rate Hospitals" to "Non Hospital-Based Clinic Reimbursement".

Subsection (d)(1) has been deleted in its entirety.

Subsection (d)(1)(A) has been deleted in its entirety.

Subsection (d)(1)(B) has been deleted in its entirety.

Subsection (d)(1)(C) has been deleted in its entirety.

Subsection (d)(2) has been deleted in its entirety.

Subsection (d)(2)(A) has been deleted in its entirety.

Subsection (d)(2)(B) has been deleted in its entirety.

Subsection (d)(3) has been deleted in its entirety.

Subsection (d)(3)(A) has been deleted in its entirety.

Subsection (d)(3)(B) has been deleted in its entirety.

Subsection (d)(4) has been deleted in its entirety.

Subsection (d)(4)(A) has been deleted in its entirety.

Subsection (d)(4)(A)(i) has been deleted in its entirety.

Subsection (d)(4)(A)(ii) has been deleted in its entirety.

Subsection (d)(4)(B) has been deleted in its entirety.

Subsection (d)(4)(B)(i) has been deleted in its entirety.

Subsection (d)(4)(B)(ii) has been deleted in its entirety.

Subsection (d)(5) has been renumbered to subsection (d)(1) and has been revised to read:

- 1) County-Operated Outpatient Facility Reimbursement

Reimbursement for all services provided by county-operated outpatient facilities, as described in Section 148.25(b)(2)(C), that do not qualify as Healthy Moms/Healthy Kids managed care clinics, as described in 89 Ill. Adm. Code 140.461(f), shall be on an all-inclusive per encounter rate basis as follows:

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Subsections (d)(5)(A) through (d)(5)(C)(iii) have become subsections (d)(1)(A) through (d)(1)(C)(iii).

In subsection (d)(1)(A)(ii), the reference to "subsection (d)(5)(A)(i)" has been changed to "subsection (d)(1)(A)(i)".

In subsection (d)(1)(A)(iii), reference to "subsection (d)(5)(A)(ii)" has been changed to "subsection (d)(1)(A)(ii)", and reference to "subsection (d)(5)(A)(i)" has been changed to "subsection (d)(1)(A)(i)".

In subsection (d)(1)(A)(iv), reference to "subsection (d)(5)(A)(iii)" has been changed to "subsection (d)(1)(A)(iii)".

In subsection (d)(1)(B)(ii), reference to "subsection (d)(5)(B)(ii)" has been changed to "subsection (d)(1)(B)(ii)", and reference to "subsection (d)(5)(B)(i)" has been changed to "subsection (d)(1)(B)(i)".

In subsection (d)(1)(B)(iii), reference to "subsection (d)(5)(B)(i)" has been changed to "subsection (d)(1)(B)(i)", and reference to "subsection (d)(5)(B)(ii)" has been changed to "subsection (d)(1)(B)(ii)".

In subsection (d)(1)(B)(iv), reference to "subsection (d)(5)(B)(iii)" has been changed to "subsection (d)(1)(B)(iii)".

In subsection (d)(1)(C)(i), reference to "subsection (d)(5)(A)(iv)" has been changed to "subsection (d)(1)(A)(iv)", and reference to "subsection (d)(5)(B)(iv)" has been changed to "subsection (d)(1)(B)(iv)".

In subsection (d)(1)(C)(ii), reference to "subsection (d)(5)(C)(i)" has been changed to "subsection (d)(1)(C)(i)".

In subsection (d)(1)(C)(iii), reference to "subsection (d)(5)(C)(ii)" has been changed to "subsection (d)(1)(C)(ii)", and reference to "subsection (d)(7)(A)" has been changed to "subsection (d)(2)".

Subsection (d)(6) has been deleted in its entirety.

Subsection (d)(7) has been renumbered to subsection (d)(2) and has been revised to read:

2) Rate Adjustments

Rate adjustments to the per encounter final rate, as described in subsection (d)(1)(C)(iii) above, shall be calculated as follows:

Subsection (d)(7)(A) has become subsection (d)(2)(A); the language "and (d)(2) through (d)(5)" has been replaced with the language "through (d)(1)(C)".

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Subsection (d)(7)(B) has become subsection (d)(2)(B), and has been revised to read:

B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

Subsection (d)(8) has been renumbered to subsection (d)(3), and has been revised to read:

3) County-operated outpatient facilities, as described in Section 148.25(b)(2)(C), shall be required to submit outpatient cost reports to the Department within 90 days of the close of the facility's fiscal year. No year-end reconciliation is made to the reimbursement calculated under this subsection (d).

Subsection (d)(9) has been renumbered to subsection (d)(4).

Section 148.150

Subsection (e), as proposed, should be deleted in its entirety. The new subsection (e) has been revised to read:

e) Condition of Eligibility - Data Requirements

A new subsection (e)(1) has been added to read:

1) Effective with the October 1, 1992, uncompensated care rate year, as a condition of eligibility for an uncompensated care payment adjustment for the uncompensated care rate year, hospitals that did not comply with the data requirements described in subsection (c) above shall submit, on or before October 21, 1992, the data required under subsection (c) above in addition to the data required under subsection (d) above.

A new subsection (e)(2) has been added to read:

2) With respect to the October 1, 1993, uncompensated care rate year:

A new subsection (e)(2)(A) has been added to read:

A) As a condition of eligibility for the total uncompensated care payment adjustment for the October 1, 1993, uncompensated care rate year, hospitals that did not comply with the data requirement described in subsection (c) above for the initial uncompensated care base year shall be required to submit, on or before October 1, 1993, the data described in subsection (c)

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above in addition to the data required under subsection (d) above.

A new subsection (e)(2)(B) has been added to read:

- B) Subject to the provision of subsection (e)(2)(C) below, a hospital that did not comply with the requirements of subsection (e)(2)(A) above on or before October 1, 1993, shall not be eligible for uncompensated care payment adjustments for the October 1, 1993, uncompensated care rate year.

A new subsection (e)(2)(C) has been added to read:

- C) Notwithstanding the provisions of subsection (e)(2)(B) above, a hospital that has failed to comply with the requirements of subsection (e)(2)(A) above on or before October 1, 1993, but does comply with such requirements on or before November 5, 1993, shall be ineligible for the first quarterly uncompensated care payment adjustment, but shall be eligible for the final three quarterly uncompensated care payment adjustments, subject to the requirements of subsection (j) of this Section.

A new subsection (e)(3) has been added to read:

- 3) Effective on or after October 1, 1994, as a condition of eligibility for an uncompensated care payment adjustment for the uncompensated care rate year, hospitals that did not comply with the data requirement described in subsection (c) above for the initial uncompensated care base year shall be required to submit, by the first day of October of the uncompensated care rate year, the data described in subsection (c) above in addition to the data required under subsection (d) above. A hospital that does not comply with these data requirements by the first day of October of the uncompensated care rate year shall be ineligible for uncompensated care payment adjustments in the uncompensated care rate year.

Section 148.160

Subsection (f)(2) has been revised to read:

- 2) In addition to the DSH payment adjustment described in Section 148.120, hospitals reimbursed under this Section shall receive supplemental DSH payments. Effective with admissions on or after October 1, 1993, supplemental DSH payments for hospitals reimbursed under this Section shall be calculated by multiplying the sum of the base year cost per diem, as described in subsection (b)(4) above, as adjusted for restructuring, as described in subsection (c) above, and as adjusted for

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inflation, as described in subsection (d) above, and the calculated disproportionate share per diem payment adjustment as described in Section 148.120, by the hospitals' percentage of charges which are not reimbursed by a third party payer for the period of August 1, 1991, through July 31, 1992. Effective October 1, 1992, the supplemental DSH payments calculated under this subsection shall be no less than the supplemental DSH rates in effect on June 1, 1992, except that this minimum shall be adjusted as of July 1, 1992, and on the first day of July of each year thereafter, by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid cost by the total allowable Medicaid days. The supplemental DSH payment adjustment shall be paid on a per diem basis and shall be applied to each covered day of care provided.

Section 148.170

The title of this Section has been revised to read:

Section 148.170 Payment Methodology for Hospitals Organized Under the University of Illinois Hospital Act

Subsection (a) has been revised to read:

- a) In accordance with 89 Ill. Adm. Code 149.50(c)(8), a hospital organized under the University of Illinois Hospital Act shall be excluded from the DRG PPS and shall be reimbursed in accordance with this Section.

Subsection (b)(1) has been revised to read:

- 1) Each hospital's base year cost per diem shall be derived from an audited cost report (see 42 CFR 447.260 and 447.265 (1982)) for hospitals' fiscal year 1990.

Subsection (d) has been revised to read:

- d) Inflation Adjustment For Base Year Cost Report Inflator

Base year costs, including any adjustments for mandated restructuring, will be updated from the midpoint of each hospital's base year to the midpoint of the fiscal year for which rates are being set according to the hospital's historical rate of annual cost increases.

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Title to Subsection (f) has been revised to read:

- f) Applicable adjustments for DSH Hospitals

Subsection (f)(1) has been revised to read:

- 1) The criteria and methodology for making applicable adjustments to DSH hospitals which are exempt from the DRG PPS as described in subsection (a) above, shall be in accordance with Section 148.120.

Subsection (f)(2) has been revised to read:

- 2) Effective October 1, 1993, in addition to the DSH payment adjustments described in Section 148.120, hospitals reimbursed under this Section shall receive supplemental DSH payments. Effective with admissions on or after October 1, 1993, supplemental DSH payments for hospitals reimbursed under this Section shall be calculated by multiplying the sum of the hospital's base year costs, as described in subsection (b) above, as adjusted for restructuring, as described in subsection (c) above, and as adjusted for inflation, as described in subsection (d) above, and the calculated disproportionate share per diem payment adjustment as described in Section 148.120, by the hospitals' percentage of charges which are not reimbursed by a third party payer for the period of August 1, 1991, through July 31, 1992. The resulting product shall be multiplied by 2.25 and this amount shall be the supplemental DSH payment adjustment which shall be paid on a per diem basis and shall be applied to each covered day of care provided.

Section 148.240

In subsection (e) the word "at" following federal regulations has been changed to "in", and "CH. IV" has been changed to "Ch. IV".

Section 148.260

In subsection (c)(2) delete language "for a hospital described in 89 Ill. Adm. Code 149.125(b)".

Section 148.290

Subsection (c)(1)(A) has been revised to read:

- A) The hospital must not be a county-owned hospital, as described in Section 148.25(b)(1)(A), or a hospital organized under the

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University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B); and

In subsection (c)(2) change "\$9,400.00" to read "\$9,400.00"

Subsection (c)(4)(A) has been revised to read:

- A) The available funds from the Trauma Center Fund for each quarter shall be divided by each eligible hospital's (as defined in subsection (c)(4) above) Medicaid trauma admissions in the same quarter of the TCA base period to determine the adjustment for the TCA rate period. The result of this calculation shall be the County TCA adjustment per Medicaid trauma admission for the applicable quarter.

Subsection (c)(7)(B) has been revised by deleting the words "Trauma" in line one, and "paid" in line three. Additionally, the entire subsection has been underlined as new language.

Subsection (c)(7)(C) has been revised to read:

- C) "Medicaid trauma admission percentage" means a fraction, the numerator of which is the hospital's Medicaid trauma admissions and the denominator of which is the total Medicaid trauma admissions in a given 12 month period for all level II urban trauma centers.

In subsection (c)(7)(F) the reference to "this subsection (c)" has been changed to read "subsection (c)(4) above".

Subsection (g)(1)(B) has been revised to read:

- B) With respect to the TAP adjustments described in subsections (g)(2) through (g)(6), the hospital must not be a county-owned hospital, as described in Section 148.25(b)(1)(A), or a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B);

In subsection (g)(1)(C) the words "and/or" have been added immediately after the words "substance abuse" and the words "or swing" immediately following the words "long term care" have been deleted.

In subsection (g)(1)(D) the words "and/or" have been added immediately after the words "substance abuse" and the words "or swing" immediately following the words "long term care" have been deleted.

In subsection (g)(5)(C) the reference to "subsection (g)(5)(B)" has been changed to "subsection (g)(5)(A)".

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In subsection (g)(8)(C) the reference to "(j)(5)(C)" has been changed to "(g)(5)(C)".

In subsection (g)(9)(A) the word "the" immediately preceeding the phrase "18 years of age" has been deleted.

In subsection (h)(1)(A)(i) the "(g)(2)" reference has been deleted.

Subsection (h)(1)(A)(ii) has been revised to read:

- ii) Not be a county-owned hospital, as described in Section 148.25(b)(1)(A), or a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B) in the MHVA rate period.

Subsection (h)(1)(D)(i) has been revised to read:

- i) Hospitals designated as Level III perinatal centers by the Illinois Department of Public Health must enter into an agreement with the Department to participate in the Healthy Moms/Healthy Kids Program as a Certified Obstetrical Ambulatory Care Center (COBACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(C), with a minimum Healthy Moms/Healthy Kids client assignment capacity commitment that includes a specified minimum number of pregnant women determined to be at medical high risk of abnormal delivery, and is otherwise mutually agreeable to both the Department and the hospital;

Subsection (h)(1)(D)(ii) has been revised to read:

- ii) Hospitals that are not designated as Level III perinatal centers by the Illinois Department of Public Health must enter into an agreement or agreements with the Department to participate in the Healthy Moms/Healthy Kids Program as a Certified Hospital Ambulatory Primary Care Center (CHAPCC), as described in 89 Ill. Adm. Code 140.461(f)(1)(A), and/or a Certified Hospital Organized Satellite Clinic (CHOSC), as described in 89 Ill. Adm. Code 140.461(f)(1)(B), with a minimum total Healthy Moms/Healthy Kids client assignment capacity commitment that is otherwise mutually agreeable to both the Department and the hospital; and

Subsection (h)(2)(D)(i) has been revised to read:

- i) The distribution method for the add-on payment described in subsection (h)(2)(D) above is based upon a fund of \$12 million. All hospitals qualifying under subsections (h)(1)(B) and (h)(1)(D) above will receive an \$85 per day add-on to their current rate. The total cost of this adjustment is calculated by multiplying each hospital's most recent completed fiscal year

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Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) by \$85. The total dollar amount of this calculation is then subtracted from the \$12 million fund.

Subsection (h)(2)(D)(ii) has been revised to read:

- ii) The remaining fund balance is then distributed to the hospitals that are located in a geographical area covered by the managed care component of the Healthy Moms/Healthy Kids Program as described in 89 Ill. Adm. Code 140.928(a)(1) in proportion to the percentage by which the hospital's Medicaid inpatient days, as described in subsection (h)(4)(D), exceeds one standard deviation above the State's mean Medicaid inpatient days, as described in subsection (h)(4)(A) of this Section. This is done by finding the ratio of each qualified hospital's percent Medicaid inpatient days to the State's mean plus one standard deviation percent Medicaid inpatient days value. These ratios are then summed and each qualified hospital's proportion of the total is calculated. These proportional values are then multiplied by each qualified hospital's most recent completed fiscal year Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization). These weighted values are summed and each qualified hospital's proportion of the summed weighted value is calculated. Each individual qualified hospital's proportional value is then multiplied against the \$12 million pool of money available after the \$85 per day base add-on has been subtracted.

Subsection (h)(2)(D)(iii) has been revised to read:

- iii) The total dollar amount calculated for each qualifying hospital under subsection (h)(2)(D)(ii) above (plus the initial \$85 per day add-on amount calculated for each qualifying hospital under subsection (h)(2)(D)(i) above) is then divided by the Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) to arrive at a per day add-on value. Hospitals meeting the criteria described under subsection (h)(1)(B)(ii), that are not located in a geographical area covered by the managed care component of the Healthy Moms/Healthy Kids Program, as described in 89 Ill. Adm. Code 140.928(a)(1), will receive the minimum adjustment of \$85 per inpatient day. The adjustments calculated under this subsection are subject to the limitations described in subsection (h)(3) below.

In subsection (h)(3)(B) the reference to subsection "(h)(2)" immediately preceeding the words "shall be pro-rated" has been changed to read "subsection (h)(2)(A) through (h)(2)(C)".

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A new subsection (h)(3)(C) has been added to read:

- C) In no instance shall the final aggregate MHVA payment adjustments calculated under subsection (h)(2)(D)(i) above for all hospitals exceed \$12 million. In the event that aggregate MHVA payment adjustments calculated under subsection (h)(2)(D)(i) exceed \$12 million, each hospital's MHVA payment adjustment calculated under subsection (h)(2)(D)(i) above shall be adjusted proportionately to ensure that the final aggregate MHVA payment adjustments calculated under subsection (h)(2)(D)(i) above for all hospitals do not exceed \$12 million.

Subsection (i) has been revised by deleting the words and acronyms "DSH Determination" in line one, "DSH" in lines two, five and ten, and "DSH status" in line seven. Additionally, the entire subsection has been underlined as new language.

Section 148.310

In subsection (a)(3)(B) the two phrases "within 30 days of" have been changed to "within 30 days after".

Subsection (e) has been revised to read:

(e) Uncompensated Care Adjustment Reviews

The Department shall make uncompensated care adjustments in accordance with Section 148.150. Hospitals shall have the right to appeal the uncompensated care rate calculation or their ineligibility for the uncompensated care rate adjustment if it is believed that a technical error has been made in the calculation. The appeal must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for uncompensated care adjustments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for the uncompensated care payment adjustment. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

Subsection (f)(4) has been revised to read:

- 4) Appeals under subsection (f) must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for trauma center

adjustments and payment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

Subsection (g) has been revised to read:

g) Rehabilitation Hospital Adjustment Reviews

The Department shall make rehabilitation hospital adjustments in accordance with Section 148.290(d). Hospitals shall have the right to appeal the rehabilitation hospital adjustment calculations if it is believed that a technical error has been made in the calculation. The appeal must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for rehabilitation hospital adjustments and payment adjustment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

Subsection (h)(3) has been revised to read:

- (3) Appeals under subsection (h) must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for perinatal center adjustments and payment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

Subsection (i) has been revised to read:

i) Obstetrical Care Adjustment Reviews

Medicaid Obstetrical Percentage. Medicaid obstetrical percentage shall be calculated in accordance with Section 148.290(f). Review shall be limited to verification that Medicaid obstetrical percentages were calculated in accordance with State regulations. The appeal must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for obstetrical care adjustments and payment amounts. Such a request shall include a

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clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

Subsection (j)(5) has been revised to read:

- (5) Appeals under subsection (j) of this Section must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for targeted access adjustments and payment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

Subsection (k) has been revised to read:

- k) Medicaid High Volume Adjustment Reviews

The Department shall make Medicaid high volume adjustments in accordance with Section 148.290(h). Review shall be limited to verification that the Medicaid inpatient days were calculated in accordance with State regulations. The appeal must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid high volume adjustments and payment adjustment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

Subsection (l) has been revised to read:

- l) Sole Community Hospital Designation Reviews

The Department shall make sole community hospital designations in accordance with 89 Ill. Adm. Code 149.125(b). Hospitals shall have the right to appeal the designation if it is believed that a technical error has been made in the determination. The appeal must be in writing and must be received within 30 days after notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

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Subsection "(m)(A)" has been changed to "(m)(1)" and revised to read:

- 1) The Department shall make rural hospital designations in accordance with Section 148.25(g)(3). Hospitals shall have the right to appeal the designation if it is believed that a technical error has been made in the determination. The appeal must be in writing and must be received within 30 days after notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

Subsection heading "(m)(B)" has been changed to "(m)(2)" and revised to read:

- 2) The Department shall make urban hospital designations in accordance with Section 148.25(g)(4). Hospitals shall have the right to appeal the designation if it is believed that a technical error has been made in the determination. The appeal must be in writing and must be received within 30 days after notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes

- 13) Will these Amendments replace Emergency Amendments currently in effect? Yes

- 14) Are there any Amendments pending on this Part? No

- 15) Summary and Purpose of Amendments: These amendments provide for extensive changes in the Department's rules governing payment for hospital services (89 Ill. Adm. Code 148). This rulemaking specifies the basic methodology for reimbursement of hospital services for Medicaid clients. Corresponding rules were effective on October 1, 1993 through emergency rulemaking which was published on October 8, 1993 at 17 Ill. Reg. 17323. This rulemaking is required to update the rules for implementation of the revised reimbursement procedures which took effect on October 1, 1993, under Public Act 88-88.

The substantive changes are as follows:

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- Effective October 1, 1993, inpatient hospital reimbursement for hospitals reimbursed under Sections 148.130, 148.260, 148.270, 148.280, and 89 Ill. Adm. Code Part 149, will be maintained at the rate in effect on June 30, 1993, with certain exceptions. Effective on and after April 1, 1994, inpatient hospital reimbursement rates for hospitals reimbursed under the above Sections will be recalculated in accordance with the new provisions contained in these proposed amendments.
- Many of the changes reflect additions to, or clarification of, definitions utilized by the Department with respect to hospital reimbursement.
- Many of the changes make reference to the Healthy Moms/Healthy Kids Program, which was effective on October 1, 1993 through emergency rulemaking which was published on October 22, 1993 at 17 Ill. Reg. 18611.
- Hospitals deemed as rural hospitals as of July 14, 1993, that were not previously deemed as rural hospitals at the beginning of the rate period (October 1, 1992), and are designated as sole community hospitals, will be given the option to be reimbursed under the Diagnosis Related Grouping (DRG) Prospective Payment System (PPS) (89 Ill. Adm. Code Part 149) or under an alternative reimbursement methodology (Section 148.260).
- Clarification has been made concerning the types of services that are covered as hospital services for the purpose of reimbursement, and additional definitions of services have been added. Clarification has also been made regarding the types of services that are not covered as hospital services for the purpose of reimbursement.
- Extensive changes have been made to the Disproportionate Share (DSH) Program under Section 148.120. The substantive changes are as follows:
 - The criteria for qualification as a DSH hospital have been changed to allow for the qualification of a hospital that, on July 1, 1991, had a Medicaid inpatient utilization rate that was at least the mean Medicaid inpatient utilization rate, and which was located in a planning area with one-third or fewer excess beds, and that, as of June 30, 1992, was located in a federally designated Health Manpower Shortage Area.
 - The Targeted Access Payment (TAP) adjustments and the Critical Care Access (CCA) payment adjustments have been moved from the DSH Program and are now provided as adjustments to the basic inpatient reimbursement programs under Section 148.290

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- (Adjustments and Reductions to Total Payments). Although the critical care access (CCA) hospitals will no longer be deemed eligible for the DSH Program unless they meet other qualifying criteria, the critical care access (CCA) hospitals will continue to receive the perinatal and obstetrical care payment adjustments that were previously provided under the DSH Program.
- The inpatient payment adjustments to DSH hospitals have been changed. These inpatient payment adjustments are now defined as "Medicaid percentage adjustments" and will be based upon each hospital's Medicaid inpatient utilization rate as follows:
 - 1) Hospitals with a Medicaid inpatient utilization rate below the mean Medicaid inpatient utilization rate will receive a payment adjustment of \$25 per inpatient day of care provided;
 - 2) Hospitals with a Medicaid inpatient utilization rate that is equal to or greater than the mean Medicaid inpatient utilization rate, but less than one standard deviation above the mean Medicaid inpatient utilization rate, will receive a payment adjustment of \$25 per inpatient day of care provided, plus \$1 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds the mean Medicaid inpatient utilization rate;
 - 3) Hospitals with a Medicaid inpatient utilization rate that is equal to or greater than one standard deviation above the mean Medicaid inpatient utilization rate, will receive a payment adjustment of \$40 per inpatient day of care provided, plus \$7 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate; and
 - 4) Hospitals with a Medicaid inpatient utilization rate that is equal to or greater than 1.5 standard deviations above the mean Medicaid inpatient utilization rate will receive a payment adjustment of \$90 per inpatient day of care provided, plus \$2 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate.
- County-owned hospitals and hospitals organized under the University of Illinois Hospital Act, as described in these proposed amendments, will receive an additional inpatient payment adjustment of \$60 per inpatient day of care provided.

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• The Medicaid percentage adjustments to a hospital, other than county-owned hospitals or hospitals organized under the University of Illinois Hospital Act, may not exceed \$155 per inpatient day of care provided for a children's hospital, and may not exceed \$215 per inpatient day of care provided for all other hospitals. These limitations shall, however, be adjusted on October 1, 1993, and annually thereafter, for inflation, as described in this proposed amendment.

• All hospitals receiving DSH payment adjustments will now receive those adjustments on a per diem basis. Previously, hospitals reimbursed on a per discharge basis received DSH payment adjustments on a per discharge basis.

• The Medicaid percentage adjustments described above will be multiplied by 2.0 for children's hospitals or by 3.75 for county-owned hospitals or hospitals organized under the University of Illinois Hospital Act.

• Section 148.130 (Outlier Adjustments for Exceptionally Costly Stays) has been revised to reflect a change in the rate period. The rate period beginning on October 1, 1992, has been extended through March 31, 1994. Effective with rate periods beginning on or after April 1, 1994, outlier adjustment rates will be calculated on April 1, 1994, using the methodologies described in this emergency amendment. Rate periods will begin 90 days after the effective date of DRG PPS rates under the federal Medicare Program and will end 90 days after any subsequent DRG PPS rate change under the federal Medicaid Program. These changes are expected to be revenue neutral.

• Numerous changes have been made in Section 148.140 (Hospital Outpatient and Clinic Services). The majority of these changes provide clarification of the current reimbursement methodology as requested by the federal Health Care Financing Administration or add reference to the Healthy Moms/Healthy Kids Program, which was effective through emergency rulemaking on October 1, 1993.

In addition to the changes described above in Section 148.140 (Hospital Outpatient and Clinic Services), hospitals eligible for reimbursement under the Hospital Ambulatory Care Program will now be eligible to receive outpatient indigent volume adjustments. These outpatient indigent volume adjustments will be calculated by multiplying the payment made by the Department under the Hospital Ambulatory Care Group II, Group III and Group IV procedures by the sum of the hospital's outpatient indigent volume factor and 1.00.

• A hospital's outpatient indigent volume factor will be calculated annually based upon a hospital's Medicaid inpatient utilization rate,

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which will be added to the hospital's uncompensated care utilization rate. The sum of this calculation will then be multiplied by 0.5.

In order to be eligible for outpatient indigent volume adjustment payments, hospitals will be required to submit the data required under Section 148.150 (Uncompensated Care Payment Adjustments) in accordance with these proposed amendments.

• The uncompensated care payment adjustment described in Section 148.150 (Uncompensated Care Payment Adjustments) will continue to be based upon the number of Medicaid days provided by the hospital in the uncompensated care base fiscal year multiplied by \$52.65. However, for the period July 1, 1993, through June 30, 1994, each hospital qualifying for an uncompensated care payment adjustment will receive an additional uncompensated care payment adjustment that will be calculated by dividing \$16.5 million by the number of Medicaid days provided by all hospitals in the uncompensated care base fiscal year.

• Section 148.160 (Payment Methodology for County-Owned Hospitals in an Illinois County with a Population of Over 3 Million) has been revised to reflect that county-owned hospitals will be treated as one hospital for the purpose of calculating the reimbursement rate for such county-owned hospitals.

• Section 148.170 (Payment Methodology for Hospitals Organized Under the University of Illinois Hospital Act) has been revised to reflect a change in the methodology for calculating the inflation adjustment. Base year costs, including any adjustments for mandated restructuring, will now be updated from the midpoint of each hospital's base year to the midpoint of the fiscal year for which rates are being set according to the hospital's historical rate of annual cost increases, as described in these proposed amendments.

In addition, hospitals organized under the University of Illinois Hospital Act will now receive supplemental DSH payment adjustments in accordance with the methodology described in these proposed amendments.

• Section 148.260 (Calculation and Definitions of Inpatient Per Diem Rates) describes the methodology for calculating inpatient reimbursement rates for psychiatric hospitals, rehabilitation hospitals, long term stay hospitals, and sole community hospitals that elect to be reimbursed under Section 148.260. This Section has been revised to reflect current policy in a number of areas.

Section 148.260 has also been revised to reflect a change in the rate period. The rate period beginning on October 1, 1992, has been

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extended through March 31, 1994. Effective with rate periods beginning on or after April 1, 1994, a number of changes will take place in the reimbursement methodology as follows:

- Reimbursement rates will be calculated on April 1, 1994, using the methodologies described in this proposed amendment. Rate periods will begin 90 days after the effective date of DRG PPS rates under the federal Medicare Program and will end 90 days after any subsequent DRG PPS rate change under the federal Medicare Program.
 - For the calculation of direct medical education costs, hospitals will be separated into two peer groups, major teaching hospitals and other teaching hospitals. The adjusted direct medical education cost per diem for all hospitals in each peer group will be calculated by utilizing the direct medical education cost per diems that were in effect on June 30, 1993. The adjusted direct medical education cost per diem will be rank ordered for all hospitals reporting such costs within each peer group, and capped at the 80th percentile. Hospitals will receive a per diem add-on for direct medical education costs in accordance with the methodology described in these proposed amendments.
 - Sole community hospitals will continue to receive an inflation adjustment based upon the national hospital market basket price proxies (DRI). Psychiatric hospitals, rehabilitation hospitals, and long term stay hospitals will receive an inflation adjustment based upon the TEHRA price inflation factor utilized under the federal Medicare Program.
 - Section 148.270 (Determination of Alternate Cost Per Diem Rates for All Hospitals; Payment Rates for Certain Exempt Hospital Units; and Payment Rates for Certain Other Hospitals) has been revised to reflect current policy in a number of areas.
- Section 148.270 has also been revised to reflect a change in the rate period. The rate period beginning on October 1, 1992, has been extended through March 31, 1994. Effective with rate periods beginning on or after April 1, 1994, a number of changes will take place in the reimbursement methodology as follows:
- Reimbursement rates will be calculated on April 1, 1994, using the methodologies described in these proposed amendments. Rate periods will begin 90 days after the effective date of DRG PPS rates under the federal Medicare Program and will end 90 days after any subsequent DRG PPS rate change under the federal Medicare Program.

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- Distinct part psychiatric units and distinct part rehabilitation units will receive an inflation adjustment based upon the TEHRA price inflation factor utilized under the federal Medicare Program.
- Section 148.280 (Reimbursement Methodologies for Children's Hospitals and Hospitals Reimbursed Under Special Arrangements) has been revised to reflect current policy.

Section 148.280 has also been revised to reflect a change in the rate period. The rate period beginning on October 1, 1992, has been extended through March 31, 1994. Effective with rate periods beginning on or after April 1, 1994, reimbursement rates for children's hospitals will be calculated on April 1, 1994, using the methodologies described in these proposed amendments. Rate periods will begin 90 days after the effective date of DRG PPS rates under the federal Medicare Program and will end 90 days after any subsequent DRG PPS rate change under the federal Medicare Program.

- Extensive changes have been made to Section 148.290 (Adjustments and Reductions to Total Payments). Many of the changes reflect clarification of current policy. The substantive changes are as follows:
 - With respect to the Level II rural trauma center adjustment (TCA), the definition of a rural hospital will change effective July 14, 1993, as described in these proposed amendments at Section 148.25(g)(3).
 - The perinatal and obstetrical adjustments previously made under the critical care access (CCA) hospital provisions of the DSH Program will now be made as adjustments to the basic inpatient reimbursement methodologies.
 - The targeted access payment (TAP) adjustments previously made under the DSH Program will now be made as adjustments to the basic inpatient reimbursement methodologies. These TAP adjustments will now be limited to Illinois hospitals.
 - Certain hospitals will now qualify for Medicaid high volume adjustments (MHVA). Hospitals that qualify for an adjustment under the DSH Program, with the exception of county-owned hospitals and hospitals organized under the University of Illinois Hospital Act, will now be eligible to receive an MHVA payment adjustment of \$60 per inpatient day of care provided. The MHVA payment adjustment for a children's hospital will be multiplied by 2.0. The MHVA adjustment described in this

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paragraph will be adjusted for inflation on October 1, 1993, and annually thereafter, as described in these proposed amendments.

Illinois hospitals that do not qualify for an adjustment under the DSH Program may also qualify for MHVA payment adjustments if the total number of Medicaid inpatient days provided by the hospital is at least one standard deviation above the mean number of Medicaid inpatient days. In order to qualify for the MHVA adjustment, hospitals located in a geographic area covered by the managed care component of the Healthy Moms/Healthy Kids Program, which is being implemented by the Department under emergency amendments to be filed shortly, will be required to meet certain criteria as described in these proposed amendments. The distribution method for the MHVA adjustment described in this paragraph will be based upon a fund of \$12 million and will be distributed in accordance with the methodology described in these proposed amendments.

- Extensive changes have been made to Section 148.310 (Review Procedure) to reflect the changes in reimbursement methodologies described above and to reflect the review process for a hospital eligible to receive primary care access health care education payments (89 Ill. Adm. Code 149.140), which was effective through emergency rulemaking which was published on October 8, 1993 at 17 Ill. Reg. 17275.

16) Information and questions regarding these Adopted Amendments shall be directed to:

Name: Joanne Jones
Address: Bureau of Rules and Regulations
Illinois Department of Public Aid
100 South Grand Avenue East, Third Floor
Springfield, Illinois 62762
Telephone: (217) 524-3215

The full text of the Adopted Amendments begins on the next page:

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TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER d: MEDICAL PROGRAMS

PART 148
HOSPITAL SERVICES

Section	
148.10	Hospital Services
148.20	Participation
148.25	Definitions and Applicability
148.30	General Requirements
148.40	Special Requirements
148.50	Covered Hospital Services
148.60	Services Not Covered as Hospital Services
148.70	Limitation On Hospital Services
148.80	Organ Transplants Services Covered Under Medicaid (Repealed)
148.82	Organ Transplant Services
148.90	Heart Transplants (Repealed)
148.100	Liver Transplants (Repealed)
148.110	Bone Marrow Transplants (Repealed)
148.120	Disproportionate Share Hospital (DSH) Adjustments
148.130	Outlier Adjustments for Exceptionally Costly Stays
148.140	Hospital Outpatient and Hospital-Based Clinic Services
148.150	Uncompensated Care Payment Adjustments
148.160	Payment Methodology for County-Owned Hospitals in an Illinois County with a Population of Over 3 Million
148.170	Payment Methodology for State-Owned Hospitals Organized Under the University of Illinois Hospital Act in an Illinois County with a Population of Over 3 Million
148.180	Payment for Pre-operative Days, Patient Specific Orders, and Services Which Can Be Performed in an Outpatient Setting
148.190	Copayments
148.200	Alternate Reimbursement Systems
148.210	Filing Cost Reports
148.220	Pre September 1, 1991, Admissions
148.230	Admissions Occurring on or after September 1, 1991
148.240	Utilization Review and Furnishing of Inpatient Hospital Services Directly or Under Arrangements
148.250	Determination of Alternate Payment Rates to Certain Exempt Hospitals
148.260	Calculation and Definitions of Inpatient Per Diem Rates
148.270	Determination of Alternate Cost Per Diem Rates For All Hospitals; and Payment Rates for Certain Exempt Hospital Units; and Payment Rates for Certain Other Hospitals
148.280	Reimbursement Methodologies for Children's Hospitals and Hospitals Reimbursed Under Special Arrangements
148.290	Adjustments and Reductions to Total Payments
148.300	Payment
148.310	Review Procedure

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- 148.320 Alternatives
- 148.330 Exemptions
- 148.340 Subacute Alcoholism and Substance Abuse Treatment Services
- 148.350 Definitions
- 148.360 Types of Subacute Alcoholism and Substance Abuse Treatment Services
- 148.368 Volume Adjustment (Repealed)
- 148.370 Payment for Subacute Alcoholism and Substance Abuse Treatment Services
- 148.373 Utilization (Repealed)
- 148.376 Utilization, Case-Mix and Discretionary Funds (Repealed)
- 148.380 Rate Appeals for Subacute Alcoholism and Substance Abuse Treatment Services
- 148.390 Hearings
- 148.400 Special Hospital Reporting Requirements

AUTHORITY: Implementing Article III of the Illinois Health Finance Reform Act (Ill. Rev. Stat. 1991, ch. 111 1/2, par. 6503-1 et seq.) [20 ILCS 2215/Art. 3] and implementing and authorized by Articles III, IV, V, VI, VII and Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1991, ch. 23, pars. 3-1 et seq., 4-1 et seq., 5-1 et seq., 6-1 et seq., 7-1 et seq., and 12-13) [305 ILCS 5/Arts. 3, 4, 5, 6, 7 and 5/12-13]

SOURCE: Sections 148.10 thru 148.390 recodified from 89 Ill. Adm. Code 140.94 thru 140.398 at 13 Ill. Reg. 9572; Section 148.120 recodified from 89 Ill. Adm. Code 140.110 at 13 Ill. Reg. 12118; amended at 14 Ill. Reg. 2553, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 11392, effective July 1, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 15358, effective September 13, 1990; amended at 14 Ill. Reg. 16998, effective October 4, 1990; amended at 14 Ill. Reg. 18293, effective October 30, 1990; amended at 14 Ill. Reg. 18499, effective November 8, 1990; emergency amendment at 15 Ill. Reg. 10502, effective July 1, 1991, for a maximum of 150 days; emergency expired October 29, 1991; emergency amendment at 15 Ill. Reg. 12005, effective August 9, 1991, for a maximum of 150 days; emergency expired January 6, 1992; emergency amendment at 15 Ill. Reg. 16166, effective November 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 18684, effective December 23, 1991; amended at 16 Ill. Reg. 6255, effective March 27, 1992; emergency amendment at 16 Ill. Reg. 11335, effective June 30, 1992, for a maximum of 150 days; emergency expired November 27, 1992; emergency amendment at 16 Ill. Reg. 11942, effective July 10, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14778, effective October 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19873, effective December 7, 1992; amended at 17 Ill. Reg. 131, effective December 21, 1992; amended at 17 Ill. Reg. 3296, effective March 1, 1993; amended at 17 Ill. Reg. 6649, effective April 21, 1993; amended at 17 Ill. Reg. 14643, effective August 30, 1993; emergency amendment at 17 Ill. Reg. 17323, effective October 1, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. _____, effective February 28, 1994.

NOTE: CAPITALIZATION DENOTES STATUTORY LANGUAGE.

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- Section 148.20 Participation
- a) Payment for hospital inpatient, and outpatient hospital and clinic services shall be made only to when provided by a hospital, as described in Section 148.25(b), or a distinct part unit, as described in Section 148.25(c), for covered services, as described in Section 148.50, and for the following types of care:
 - 1) General/Specialty
 - 2) Psychiatrist
 - 3) Rehabilitation, and
 - 4) End Stage-Renal-Disease-Treatment

b) Notwithstanding any other provisions of this Part, reimbursement to hospitals for services provided October 1, 1992, through March 31, 1994, July 1, 1992-through-September-30, 1992, shall be as follows:

1) Base Inpatient Payment Rate. For inpatient hospital services rendered, or, if applicable, for inpatient hospital admissions occurring, on and after October 1, 1992, July 1, 1992, and on or before March 31, 1994, September 30, 1992, the Department shall reimburse hospitals for inpatient services under the reimbursement methodology in effect for each hospital, and at the base inpatient payment rate calculated for each hospital, as of June 30, 1993 June 30, 1992. The term "base inpatient payment rate" shall include the reimbursement rates calculated effective October 1, 1992, under the following Sections: 148.130, 148.260, 148.270, and 148.280.

2) Exemptions. The provisions of subsection (b)(1) above shall not apply to:

- A) Hospitals reimbursed under Sections 148.82, 148.160, or 148.170. Reimbursement for such hospitals shall be in accordance with Sections 148.82, 148.160, or 148.170, as applicable.
- B) Hospitals reclassified as rural hospitals as described in Section 148.40(f)(4). Reimbursement for such hospitals shall be in accordance with Section 148.40(f)(4) and Section 148.260 or 89 Ill. Adm. Code 149.100(c)(1)(A), whichever is applicable.
- C) The inpatient payment adjustments described in Sections 148.120, 148.150, and 148.290. Reimbursement for such

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Section 148.20(b)(2)(C) (continued)

inpatient payment adjustments shall be in accordance with Sections 148.120, 148.150, and 148.290, and shall be in addition to the base inpatient payment rate described in subsection (b)(1) above.

For the purpose of calculating the inpatient payment rate for each hospital eligible to receive quarterly payment adjustments for targeted access and critical care, as defined by the Department on June 30, 1992, the payment adjustment for the period July 1, 1992 through September 30, 1992, shall be 25 percent of the annual adjustments calculated for each eligible hospital, as of June 30, 1992.

- 3) For the purpose of calculating the inpatient payment rate for each hospital eligible to receive quarterly payment adjustments for uncompensated care, as defined by the Department on June 30, 1992, the payment adjustment for the period August 1, 1992 through September 30, 1992, shall be one-sixth of the total uncompensated care payment adjustment calculated for each eligible hospital for the uncompensated care rate year, as defined by the Department, ending on July 31, 1992.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 148.25 Definitions and Applicability

- a) Payment for hospital inpatient, hospital outpatient and hospital hospital-based clinic services shall be made only to a hospital or a distinct part hospital unit as defined in this Section.

- b) The term "hospital" means:

- 1) For the purpose of hospital inpatient reimbursement, any institution, place, building, or agency, public or private, whether organized for profit or not-for-profit, which is located in the State and is subject to licensure by the Illinois Department of Public Health under the Hospital Licensing Act or any institution, place, building or agency, public or private, whether organized for profit or not-for-profit, which meets all comparable conditions and requirements of the Hospital Licensing Act in effect for the state in which it is located. In addition, unless specifically indicated otherwise, for the purpose of inpatient reimbursement, the term "hospital" shall also include: A county-owned hospital in a county with a population of over 3 million and a state-owned hospital in a county with a population of over 3 million.

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Section 148.25(b)(1) (continued)

- A) County-owned hospitals, shall mean all county-owned hospitals, that are located in an Illinois county with a population of over three million. The term "county-owned hospital in a county with a population of over 3 million" means a hospital, as defined in subsection (b)(1) above, that is located in the State of Illinois.
- B) The term "State-owned A hospital in a county with a population of over 3 million" means a hospital, as defined in and/or hospitals organized under the University of Illinois Hospital Act.
- C) A hospital unit that is adjacent to or on the premises of the hospital and licensed under the Hospital Licensing Act or the University of Illinois Hospital Act.
- 2) For the purpose of hospital outpatient and hospital-based- clinic reimbursement, the term "hospital" shall, in addition to the definition described in subsection (b)(1) above, include an encounter rate hospital. An encounter rate hospital is defined as:
- A) An Illinois county-owned hospital located in a county with a population exceeding 3 million; or
- B) An Illinois county-owned hospital located in a county with a population exceeding 3 million that has provided and that has been paid for 85,000 days or more of inpatient-hospital care to recipients of medical assistance during State Fiscal Year 1989, or
- B) C) A hospital and/or hospitals organized under the University of Illinois Hospital Act. An Illinois state-owned hospital located in a county with a population exceeding 3 million; or
- C) D) A county-operated outpatient facility located in a county with a population exceeding 3 million that is also located in the State of Illinois.
- 3) For the purpose of hospital inpatient and outpatient reimbursement, the term "hospital" shall, in addition to the definitions described in subsections (b)(1) and (b)(2) above, include a hospital unit that is adjacent to or on the premises of the hospital and licensed under the Hospital Licensing Act.

Section 148.25(b) (continued)

3) For the purpose of non hospital-based clinic reimbursement, the term "hospital" shall mean:

- A) A county-operated outpatient facility, as described in subsection (b)(2)(D) above; or
- B) A Certified Hospital Organized Satellite Clinic, as described in 89 Ill. Adm. Code 140.461(f)(1)(B) and subsection (b)(5)(B) below.

4) For the purpose of hospital-based clinic reimbursement, the term "hospital" shall, in addition to the definitions described in subsections (b)(1) and (b)(2) above, mean include a hospital-based clinic meeting the provisions of 89 Ill. Adm. Code Section 140.461(a) and Section 148.40(d) 140.461(a)(2).

5) For the purpose of Healthy Moms/Healthy Kids reimbursement, as described in 89 Ill. Adm. Code 140.464 and Section 148.440(d)(6), the term "Healthy Moms/Healthy Kids managed care clinic" shall mean a clinic meeting the requirements of 89 Ill. Adm. Code 140.461(f). The following four categories of Healthy Moms/Healthy Kids managed care clinics are recognized under the Healthy Moms/Healthy Kids Program, as described in 89 Ill. Adm. Code 140. Subpart G:

- A) Certified Hospital Ambulatory Primary Care Centers (CHAPCC), as described in 89 Ill. Adm. Code 140.461(f)(1)(A);
- B) Certified Hospital Organized Satellite Clinics (CHOSC), as described in 89 Ill. Adm. Code 140.461(f)(1)(B);
- C) Certified Obstetrical Ambulatory Care Centers (COBACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(C); and
- D) Certified Pediatric Ambulatory Care Centers (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D).

c) For the purpose of hospital inpatient reimbursement, the term "distinct part hospital unit" means a hospital, as defined in subsection (b)(1) above, that meets the following qualification(s):

- 1) Distinct Part Psychiatric Units. A distinct part psychiatric unit is a hospital, with a functional psychiatric unit, that is enrolled with the Department to provide inpatient psychiatric services (category of service 21).

Section 148.25(c) (continued)

- 2) Distinct Part Rehabilitation Units. A distinct part rehabilitation unit is a hospital, with a functional rehabilitation unit, that is enrolled with the Department to provide inpatient rehabilitation services (category of service 22).

d) A major teaching hospital is defined as a hospital having four or more graduate medical education programs accredited by the American Accreditation Council for Graduate Medical Education, the American Osteopathic Association Division of Post-doctoral Training, or the American Dental Association Joint Commission on Dental Accreditation. Except, in the case of a hospital devoted exclusively to physical rehabilitation, as defined in 89 Ill. Adm. Code 149.50(c)(2) Section 149.50(e), or in the case of a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3), only one certified program is required to be so classified.

e) Except as provided in subsection (d) above, a teaching hospital is defined as a hospital having at least one, but no more than three, graduate medical education programs accredited by the American Accreditation Council for Graduate Medical Education, the American Osteopathic Association Division of Post-doctoral Training, or the American Dental Association Joint Commission on Dental Accreditation.

f) A non-teaching hospital is defined as:

- 1) A hospital that reports teaching costs on the Medicare or Medicaid cost reports but has no graduate medical education programs; or
- 2) A hospital that reports no teaching costs on the Medicare or Medicaid cost reports and that has no graduate medical education programs.

g) Definitions. Unless specifically stated otherwise, the definitions of terms used in Sections 148.160, 148.170, 148.130, 148.260, 148.270, and 148.280, and in 89 Ill. Adm. Code 149 are as follows:

- 1) "Base period" means the two most recent cost report years for which audited cost reports are available for at least 90 percent of cost reporting all hospitals.

2) "Rate period" means:

- A) For admissions, or if applicable, dates of service, on or after October 1, 1992, and on or before March 31, 1994, the

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Section 148.25(g)(2)(A) (continued)

eighteen month period beginning on October 1, 1992, and ending on March 31, 1994.

- B) Beginning beginning with admissions, or if applicable, dates of service, on or after April 1, 1994, October 1, 1992, the twelve-month period beginning 90 days after the effective date of DRG PPS rates under the federal Medicare Program on October 1 of the year and ending 90 days after any subsequent DRG PPS rate change under the federal Medicare Program September 30 of the following year.

3) "Rural hospital" means a hospital that is:

- A) Located:
- i) Outside a metropolitan statistical area; or
 - ii) Located 15 miles or less from a county that is outside a metropolitan statistical area and that is licensed to perform medical/surgical or obstetrical services and has a combined approved total bed capacity of 75 or fewer beds in these two service categories as of the effective date of P.A. 88-88 (July 14, 1993), as determined by the Illinois Department of Public Health.

- B) The Illinois Department of Public Health must have been notified in writing of any changes to a facility's bed count on or before the effective date of P.A. 88-88 (July 14, 1993).

- 4) "Urban hospital" means a hospital that is located in a metropolitan statistical area that does not meet the criteria described in subsection (g)(3) above.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 148.40 Special Requirements

a) Inpatient Psychiatric Services

- 1) Payment for inpatient hospital psychiatric services shall be made only to:
 - A) A hospital that is a general hospital, as defined in Section 148.25(b), with a functional unit, as defined in

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Section 148.40(a)(6) (continued)

hospitals located in the State of Illinois, or within a 100 mile radius of the State of Illinois, must execute a Coordination of Care Agreement in order to participate as a provider of inpatient psychiatric services. The Coordination of Care Agreement shall set forth an agreement between the DMHDD-operated mental health center (State-operated facility) and the hospital for the coordination of services, including but not limited to crisis screening and discharge planning to ensure efficient use of inpatient care. The agreement shall also set forth the manner in which linkage to aftercare services with community mental health agencies or private practitioners shall be carried out.

7) Coordination of Care - General Provisions. The general provisions of the Coordination of Care Agreement described in subsection (a)(6) above are as follows:

- A) The hospital shall agree, on a continuing basis, to comply with applicable licensing standards as contained in State laws or regulations and shall maintain accreditation by JCAHO;
- B) The provider shall comply with Title VI of the Civil Rights Act of 1964 and the Rehabilitation Act of 1973 and regulations promulgated thereunder which prohibit discrimination on the grounds of sex, race, color, national origin or handicap;
- C) The provider shall comply with the following applicable federal, State and local statutes pertaining to equal employment opportunity, affirmative action, and other related requirements: 42 U.S.C.A. 2000e (1981), 29 U.S.C.A. 203 et seq. (1982), Ill. Rev. Stat. 1991, ch. 68, pars. 101 et seq. [775 ILCS 25/1-et-seq.].
- D) The Coordination of Care Agreement shall remain in effect until amended by mutual consent or cancelled in writing by either party having given thirty (30) days prior notification.
- 8) Coordination of Care - Special Requirements. The hospital shall:
 - A) Provide on its premises the facilities, staff, and programs for the diagnosis, admission, and treatment of persons who may require inpatient care and/or assessment of mental status, mental illness, emotional disability, and other psychiatric problems;

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Section 148.40(a)(6) (continued)

B) With the written consent of the individual, notify the community mental health agency that serves the geographic area from which the recipient originated to allow the agency to prescreen the case prior to referring the individual to the designated State-operated facility. The community mental health agency's resources and other appropriate community alternatives shall be considered prior to making a referral to the State-operated facility for admission;

C) Complete any forms necessary and consistent with the Mental Health and Developmental Disabilities Code in the event of a referral for involuntary or judicial admission;

D) With the written consent of the individual, notify the community mental health agency or private practitioner of the date and time of discharge and invite their participation in the discharge planning process;

E) Refer to the State-operated facility only those individuals for whom less restrictive alternatives are documented not to be appropriate at the time based on a clinical determination by the community mental health agency, a private practitioner (if applicable), or the hospital; and

F) Notify the State-operated facility prior to planned transfer of an individual and transfer the individual at such time as to assure arrival of the person prior to 11 a.m. Monday through Friday. In unusual situations, transfers may be made at other times after prior discussion between the hospital and the State-operated facility. The individual will only be transported to the State-operated facility when, based on a clinical determination, he/she is medically stable as determined by the transferring physician. A copy of the transfer summary from the hospital must accompany the recipient at the time of admission to the State-operated facility.

9) Coordination of Care - Special Requirements of the State-Operated Facility. The State-operated facility shall:

A) Admit individuals who have been screened as defined in the Coordination of Care Agreement and are appropriate for admission consistent with the provisions of the Mental Health and Developmental Disabilities Code.

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Section 148.40(a)(9) (continued)

B) Evaluate individuals for whom the hospital has executed a Petition and Certificate for involuntary/judicial admission consistent with the Mental Health and Developmental Disabilities Code.

C) Consider for admission voluntary individuals for whom less restrictive alternatives are documented not to be appropriate at the time, based on a clinical determination by the community mental health agency, private practitioner (if applicable), the hospital, or the State-operated facility.

10) A participating hospital not enrolled for inpatient psychiatric services may provide psychiatric care as a general inpatient service only on an emergency basis for a maximum period of 72 hours or in cases in which the psychiatric services are secondary to the services for which the period of hospitalization is approved.

b) Inpatient Rehabilitation Services

1) Payment for inpatient rehabilitation services shall be made only to a general hospital, as defined in Section 148.25(b), with a functional unit of the hospital, as defined in Section 148.25(c)(2), which specializes in, and is enrolled with the Department to provide, physical rehabilitation services or a hospital, as defined in 89 Ill. Adm. Code 149.50(c)(2), which holds a valid license as, and is enrolled with the Department as, a physical rehabilitation hospital.

2) The primary reason for hospitalization is to provide a structured program of comprehensive rehabilitation services, furnished by specialists, to the patient with a major handicap for the purpose of habilitating or restoring the person to a realistic maximum level of functioning.

3) Inpatient rehabilitation services are not covered for Family and Children Assistance (formerly known as General Assistance) program participants who are 18 years of age or older.

4) For payment to be made, a rehabilitation facility, which includes a distinct part unit as described in Section 148.25(c)(2), must be certified by the Health Care Financing Administration for participation under the Medicare Program (Title XIII) and must be licensed and/or certified by the Illinois Department of Public Health to provide comprehensive

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Section 148.40(b)(4) (continued)

physical rehabilitation services. Out-of-state hospitals that specialize in physical rehabilitation services must be licensed or certified to provide comprehensive physical rehabilitation services by the authorized licensing agency in the state in which the hospital is located.

- 5) A rehabilitation facility must meet the following criteria:
 - A) Have a full-time (at least 35 hours per week) director of rehabilitation; a participating general hospital with a functional rehabilitation unit must have a part-time (at least 20 hours per week) director of rehabilitation;
 - B) Have an organized medical staff;
 - C) Have available consultants qualified to perform services in appropriate specialties;
 - D) Have adequate space and equipment to provide comprehensive diagnostic and treatment services;
 - E) Maintain records of diagnosis, treatment progress (notations must be made at regular intervals) and functional results; and
 - F) Submit reports as required by the Department of Public Aid.
- 6) A rehabilitation facility must provide, or have a contractual arrangement with an appropriate entity or agency to provide, the following minimal services:
 - A) Full-time nursing services under the supervision of a registered nurse formally trained in rehabilitation nursing;
 - B) Full-time physical therapy and occupational therapy services; and
 - C) Social casework services as an integral part of the rehabilitation program.
- 7) A rehabilitation facility must have available the following minimal services:
 - A) Psychological evaluation services;
 - B) Prosthetic and orthotic services;

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Section 148.40(b)(7) (continued)

- C) Vocational counseling;
- D) Speech therapy;
- E) Clinical laboratory and x-ray services; and
- F) Pharmacy services.

8) The director of rehabilitation must meet the following criteria:

- A) Provide services to the hospital and its patients as specified in subsection (b)(5) above;
 - B) Be a doctor of medicine or osteopathy;
 - C) Be licensed under State law to practice medicine or surgery; and
 - D) Must have, after completing a one-year hospital internship, at least two years of training or experience in the medical management of inpatients requiring rehabilitation services.
- 9) Personnel of the rehabilitation facility must meet the following minimum standards:

- A) Physicians shall have unlimited licenses to practice medicine and surgery in the state in which they practice. Consultants shall be Board Qualified or Board Certified in their specialty.
- B) Physical therapists shall be licensed by the Illinois Department of Professional Regulation.
- C) Occupational therapists shall be licensed by the Illinois Department of Professional Regulation.
- D) Registered nurses and licensed practical nurses shall be currently licensed by the Illinois Department of Professional Regulation or comparable licensing agency in the State in which the facility is located.
- E) Social workers shall have completed two years of graduate training leading to a Master's Degree in social work from an accredited graduate school of social work.
- F) Psychologists shall have a Master's Degree in clinical psychology.

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Section 148.40(b)(9) (continued)

- G) Vocational counselors shall have a Master's Degree in Rehabilitation Counseling, Psychology or Guidance from a school accredited by the North Central Association or its equivalent.
- H) An orthotist or prosthetist, certified by the American Board of Certification in Orthotics and Prosthetics shall fabricate or supervise the fabrication of all limbs and braces.
- c) End-Stage Renal Disease Treatment (ESRDT) Services. The Department provides payment to hospitals, as defined in Section 148.25(b), for ESRDT services only when the hospital is Medicare certified for ESRDT and services are provided as follows:
- 1) Inpatient hospital care is provided for the evaluation and treatment of acute renal disease;
 - 2) Outpatient chronic renal dialysis treatments are provided in the outpatient renal dialysis department of the hospital, a satellite unit of the hospital that is professionally associated with the center for medical direction and supervision, or a free-standing chronic dialysis center certified by Medicare, pursuant to 42 CFR 405, Subparts S and U (1984), and the recipient is approved by the Illinois Department of Public Health (IDPH) or the Department of Health and Human Services (DHHS) as eligible for ESRDT services; or
 - 3) Home dialysis treatments are provided through the outpatient renal dialysis department of the hospital, a satellite unit of the hospital that is professionally associated with the center for medical direction and supervision, in a patient's home, or through a free-standing chronic dialysis center certified by Medicare, pursuant to 42 CFR 405, Subparts S and U (1984), and the recipient is approved by the Illinois Department of Public Health (IDPH) or the Department of Health and Human Services (DHHS) as eligible for ESRDT services.
- d) Hospital-Based Organized Clinic Services. Hospital-based clinics, as described in Section 148.25(b)(4), must meet the requirements of 89 Ill. Adm. Code 140.461(a) 140.461(a)(3). The following four categories of hospital based organized clinic services are recognized in the Medical Assistance Program:
- 1) General Clinic Services. General clinic services are diagnostic, therapeutic and palliative services provided under

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Section 148.40(d)(1) (continued)

- the direction of a physician who provides for the health care needs of persons who elect to use this type of service rather than another source of primary care. In order to participate as a provider of general clinic services, a hospital must meet the following requisites:
- A) The hospital must be enrolled for participation in the Medical Assistance Program to provide general inpatient (category of service 20) and general outpatient (category of service 24) hospital services.
- B) Personnel
- i) The clinic must be organized as a distinct hospital department with a qualified, trained executive in charge of all activities and responsible to the administration of the hospital;
 - ii) An advisory medical council must function to assist the executive officer in formulating policies for the management and care of clinic patients;
 - iii) The qualifications of the medical staff of the clinic must meet the same requirements that apply to the hospital staff;
 - iv) Nursing services must be provided by licensed nurses under the supervision of a registered professional nurse (R.N.); and
 - v) A dietitian must be available to instruct the patients regarding special diets and to plan with the patients in the buying and preparation of food.
- C) Program
- i) The program of the clinic must ensure the provision of comprehensive, high quality, personalized, and continuous health care services to its patients. This means that, at a minimum, the clinic must provide or contract for the services of a sufficient number of primary and specialty care physicians to meet the health needs of patients of the clinic, and must have provisions made for the back-up care of patients when the clinic is not open;

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- ii) The laboratory, x-ray, and special therapy services must be available for clinic patients, as needed;
- iii) The pharmacy must be an integral part of the clinic organization; and
- iv) The medical social services in the clinic must be integrated with those in the hospital.

D) Physical Setting and Equipment. The size, location, ventilation, and lighting of accommodations for interviewing, examining, and treating patients and appropriate equipment must be adequate to serve the number and needs of patients accepted by the clinic;

E) Records

- i) Clinic records must accurately reflect the patient's condition and contain all significant facts bearing on the case, i.e., history, symptoms and complaints, physical examination findings, laboratory and x-ray procedures, and medications ordered and their results, diagnosis, treatment given or recommended and the patient's response to treatment; and

- ii) Clinic records must contain the dates of service and the name of the medical practitioner seeing the patient at the time of each clinic visit.

2) Psychiatric Clinic Services

- A) Psychiatric Clinic Services (Type A). Type A psychiatric clinic services are clinic service packages consisting of diagnostic evaluation; individual, group and family therapy; medical control; optional Electroconvulsive Therapy (ECT); and counseling, provided in the hospital clinic setting for individuals through the age of twenty-one (21).
- B) Psychiatric Clinic Services (Type B). Type B psychiatric clinic services are active treatment programs in which the individual patient is participating in no less than social, recreational, and task-oriented activities at least four (4) hours per day at a minimum of three (3) half days of active treatment per week. The duration of an individual patient's participation in this treatment program is

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Section 148.40(d)(2)(B) (continued)

limited to six (6) months in any twelve (12) month period.

- C) Coverage. Psychiatric clinic services are covered for all Medicaid-eligible individuals. The services are not covered for Family and Children Assistance (formerly known as General Assistance) program participants who are 18 years of age or older.

D) Approval. The Illinois Department of Mental Health and Developmental Disabilities (DMHDD) and the Illinois Department of Public Aid (IDPA) are responsible for approval and enrollment of community hospitals providing psychiatric clinic services. In order to participate as a provider of psychiatric clinic services, a hospital must be enrolled for the provision of inpatient psychiatric services and execute a Psychiatric Clinic Services Type A and B Enrollment Assurance with DMHDD and the Department, which assures that the hospital is enrolled for the provision of inpatient psychiatric services and meets the following requisites:

- i) The hospital must be accredited by, and be in good standing with, the Joint Commission on Accreditation of Health Care Organizations (JCAHO);
- ii) The hospital must have executed a Coordination of Care Agreement between the hospital and the designated Illinois Department of Mental Health and Developmental Disabilities' State-operated facility serving the mentally ill in the appropriate geographic area;
- iii) The clinical staff of the psychiatric clinic must collaborate with the mental health service network to provide discharge, linkage and aftercare planning for recipients of outpatient services;
- iv) The hospital must agree to participate in Local Area Networks in compliance with P.L. 99-660 and P.A. 86-844; and
- v) The hospital must be enrolled to participate in Medicaid Program (Title XIX) and must meet all conditions and requirements set forth by the Illinois Department of Public Aid.

E) Duration of Approval. The approval described in subsection

Section 148.40(d)(2)(E) (continued)

(d)(2)(D) above shall be in effect for a period of two years from the date IDPA approves the psychiatric clinic's enrollment. The approval may be terminated by IDPA or DMHDD with cause upon thirty-(30) days written notice to the hospital. Accordingly, the hospital must submit a thirty-(30) day written notification to IDPA and DMHDD when terminating delivery of psychiatric clinic services.

3) Physical Rehabilitation Clinic Services

A) Physical rehabilitation clinic services include the same rehabilitative services provided to inpatients by hospitals enrolled to provide the services described in Section 148.40(b). Clinic services should be utilized when the patient's condition is such that it does not necessitate inpatient care and adequate care and treatment can be obtained on an outpatient basis through the hospital's specialized clinic.

B) Physical rehabilitation clinic services are not covered for Family and Children Assistance (formerly known as General Assistance) program participants who are 18 years of age or older.

6) Healthy Moms/Healthy Kids Managed Care Clinics. Healthy Moms/Healthy Kids managed care clinics, as described in 89 Ill. Adm. Code 140.461(f) and Section 148.25(b)(5), must meet the requirements of 89 Ill. Adm. Code 140.461(f).

4) Transition to the Diagnosis Related Grouping Prospective Payment System (DRG PPS)

1) Effective with admissions occurring on or after September 1, 1991, and before October 1, 1992, hospitals shall be reimbursed in accordance with the statutes and administrative rules governing the time period when the services were rendered. Sections 148.80, 148.160, 148.170, 148.260 through 148.200, or 89-111, Adm. Code 140, as applicable, Hospital designated as sole community hospitals effective September 1, 1991, shall retain that designation and continue to be reimbursed under the methodology that was in effect on June 30, 1992, for the period July 1, 1992, through September 30, 1992. Hospitals that, on August 21, 1991, had a contract in effect with the Department under the Illinois Health Finance Reform Act (111 Rev. Stat. 1991, ch. 23, par. 6501.1 et seq.) that elected to continue to be reimbursed at rates stated in such contracts for general and

Section 148.40(f)(1) (continued)

specialty care effective September 1, 1991, shall continue to be reimbursed at rates stated in such contracts for general and specialty care for the period July 1, 1992, through September 30, 1992.

2) Effective with admissions occurring on or after October 1, 1992, hospitals that, on August 31, 1991, had a contract in effect with the Department under the Illinois Health Finance Reform Act (111 Rev. Stat. 1991, ch. 23, par. 6501.1 et seq.) and that elected, effective September 1, 1991, to be reimbursed at rates stated in such contracts, may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care in accordance with subsection (g) of this Section.

3) In the case of a hospital that was determined by the Department to be a rural hospital at the beginning of the rate period described in Section 148.25(g)(2)(A), effective October 1, 1992, for hospitals located in rural areas, those hospitals that shall be treated as sole community hospitals, as described in 89 Ill. Adm. Code 149.125(b), shall elect one of the following payment methodologies to be used by the Department in reimbursing that hospital for inpatient services during the rate period described in Section 148.25(g)(2)(A):

- A) the DRG PPS, as described in 89 Ill. Adm. Code 149, or
- B) the rate calculated under Section 148.260 Sections 148.260 through 148.300.

4) In the case of a hospital that was not determined by the Department to be a rural hospital at the beginning of the rate period described in Section 148.25(g)(2)(A), but was subsequently reclassified by the Department as a rural hospital, as described in Section 148.25(g)(3), on July 14, 1993, those hospitals that shall be treated as sole community hospitals, as described in 89 Ill. Adm. Code 149.125(b), shall elect one of the following payment methodologies to be used by the Department in reimbursing that hospital for inpatient admissions, or, if applicable, for inpatient services provided on October 1, 1993, and for the duration of the rate period described in Section 148.25(g)(2)(A):

- A) the DRG PPS, as described in 89 Ill. Adm. Code 149, subject to the provisions of 89 Ill. Adm. Code 149.100(c)(1), or

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B) the rate calculated under Section 148.260 that would have been in effect for the rate period described in Section 148.25(g)(2)(A) if the hospital had been designated as a sole community hospital on October 1, 1992.

5) For the rate periods described in Section 148.25(g)(2)(B), hospitals, as described in 89 Ill. Adm. Code 149.125(b), shall elect one of the following payment methodologies to be used by the Department in reimbursing that hospital for inpatient admissions, or, if applicable, for inpatient services provided during such rate periods described in Section 148.25(g)(2)(B):

- A) the DRG PPS, as described in 89 Ill. Adm. Code 149, subject to the provisions of 89 Ill. Adm. Code 149.100(c)(1), or
- B) the rate calculated under Section 148.260.

g) Annual Irrevocable Election

1) Hospitals described in subsections (f)(2) and (f)(3) (e)(2)-and (e)(3) above may elect to be reimbursed under the special arrangements described in subsections (f)(2) and (f)(3) (e)(2)-and (e)(3) above at the beginning of each rate period.

2) Hospitals described in subsection (f)(4) above may elect to be reimbursed under the special arrangements described in subsection (f)(4) above effective with admissions, or, if applicable, with inpatient services provided, on October 1, 1993, and for the duration of the rate period described in Section 148.25(g)(2)(A).

3) Hospitals described in subsection (f)(5) above may elect to be reimbursed under the special arrangements described in subsection (f)(5) above at the beginning of each rate period described in Section 148.25(g)(2)(B).

4) Once a sole community hospital elects to be reimbursed under the DRG PPS, it may not later in that rate period elect to be classified as exempt. Once a sole community hospital elects to be reimbursed as exempt, it may not later in that rate period elect to be reimbursed under the DRG PPS.

5) Hospitals that, on August 31, 1991, had a contract with the Department under the Illinois Health Finance Reform Act may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care. Once such election

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Section 148.40(g)(5) (continued)

has been made, the hospital may not later in that rate period elect to be reimbursed under any other methodology.

6) Hospitals that, on August 31, 1991, had a contract with the Department under the Illinois Health Finance Reform Act and have elected to be reimbursed under the DRG PPS may not later elect to be reimbursed at rates stated in such contracts.

h) Notification of Reimbursement Methodology

- 1) Hospitals shall receive notification from the Department with respect to the reimbursement methodologies that shall be in effect for admissions occurring during the rate period.
- 2) Hospitals described in subsections (f)(2), (f)(3), (f)(4), and (f)(5) (e)(2)-and (e)(3) above shall receive notification of their reimbursement options accompanied by a Choice of Reimbursement form. Each hospital described in subsections (f)(2), (f)(3), (f)(4), and (f)(5) (e)(2)-and (e)(3) above shall have thirty-(30) days from the date of such notification to file, with the Department, the reimbursement method of choice for the rate period. In the event the Department has not received the hospital's Choice of Reimbursement form within thirty-(30) days from the date of notification, as described above, the hospital will automatically be reimbursed for the rate period under the reimbursement methodology that would have been in effect without benefit of the election described in subsection (g) (f) above.

i) Zero Balance Bills. The Department requires a hospital to submit a bill for any inpatient service provided to an Illinois Medicaid eligible person, including newborns, regardless of payor. A "zero balance bill" is one on which the total "prior payments" are equal to or exceed the Department's liability on the claim. The Department requires that zero balance bills be submitted subsequent to discharge in the same manner as are other bills so that information can be available for the maintenance of accurate patient profiles and diagnosis-related grouping (DRG) data, and information needed for calculation of disproportionate share and other rates. The provisions of this subsection apply to all hospitals regardless of the reimbursement methodology under which they are reimbursed.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

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Section 148.50 Covered Hospital Services

a) The Department shall pay hospitals for the essential provision of inpatient, outpatient, and hospital-based clinic diagnostic and treatment services not otherwise excluded or limited which are provided by a hospital, as described in Section 148.25(b), or a distinct part unit, as described in Section 148.25(c), and which are provided in compliance with hospital licensing standards. Payment may be made for the following types of care subject to the special requirements described in Section 148.40:

- 1) General/specialty services;
 - 2) Psychiatric services;
 - 3) Rehabilitation services; and
 - 4) End-Stage Renal Disease Treatment (ESRDT) services.
- b) Certain programs are administered as hospital covered services with certain restrictions. These programs include hospital residing long term care services, subacute alcoholism and substance abuse treatment services, and the transplant program.

c) Hospital Residing Long Term Care Services

1) Long term care services are not considered by the Department to be hospital services unless the hospital is enrolled with the Department specifically to provide hospital residing long term care services as a hospital-based long term care facility. Hospital residing long term care is care provided by hospitals to non-acute patients requiring chronic, skilled nursing care when a skilled nursing facility bed is not available, or non-acute care provided by hospitals that is not routinely performed within a skilled setting, such as ventilator care, when appropriate placements are not available to discharge the patient. Hospitals may not utilize the following beds or facilities for hospital services unless the hospital is enrolled with the Department to provide hospital residing long term care:

- A) A special unit or specified beds which are certified for skilled nursing facility services under the Medicare Program; or
- B) A special unit or separate facility administratively associated with the hospital and licensed as a long term care facility.

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Section 148.50(c) (continued)

2) There are three categories of service for hospital residing long term care. These categories are as follows:

A) Skilled Care - Hospital Residing (category of service 37)

Reimbursement is available for hospitals providing hospital residing long term care when the patients' needs reflect routine skilled care and the inability to place the patient is due to unavailability of a skilled nursing bed. Reimbursement for this type of care is at the average statewide rate for skilled nursing care. For a hospital to be eligible for such reimbursement, the following criteria must be met:

- i) The hospital must document its attempt to place the patient in at least five appropriate facilities.
- ii) Documentation (form DPA 3127) must be attached to the appropriate claim form and submitted to the Department.
- iii) Reimbursement is limited to services provided after the minimum number of contacts have been made. Reimbursement will not be made for services which were billed as acute inpatient care and denied as not being medically necessary. Reimbursement will be made for up to a maximum of 31 days before additional documentation must be submitted to extend the eligibility for additional reimbursement.

B) Exceptional Care - Hospital Residing (category of service 38)

Reimbursement is available for hospitals providing hospital residing long term care when the level of care is not routinely performed within a skilled setting, such as ventilator care, and the patient cannot be placed in a skilled nursing facility because the level of care is not available. Exceptional care is defined by the Department as the level of care required by persons who are medically stable and ready for discharge from a hospital but who require a multi-disciplinary level of care for physician, nurse, and ancillary specialist services with exceptional costs related to extraordinary equipment and supplies that have been determined to be a medical necessity. This includes, but is not limited to, persons with acquired immune deficiency syndrome (AIDS) or a related condition.

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Section 148.50(c)(2)(B) (continued)

head injured persons, and ventilator dependent persons. Reimbursement for this type of care is at the average statewide rate for exceptional care. For a hospital to be eligible for such reimbursement, the following criteria must be met:

- i) The hospital must document its attempt to place the patient in at least five appropriate facilities.
- ii) Documentation (form DPA 3127) must be attached to the appropriate claim form and submitted to the Department.
- iii) Reimbursement is limited to services provided after the minimum number of contacts have been made. Reimbursement will not be made for services which were billed as acute inpatient care and denied as not being medically necessary. Reimbursement will be made for up to a maximum of 31 days before additional documentation must be submitted to extend the eligibility for additional reimbursement.

C) DD/MI Non-Acute Care - Hospital Residing (category of service 39)

Reimbursement is available for hospitals providing hospital residing long term care when the pre-admission screening agent has not completed the assessment, planning or discharge process. Reimbursement for this type of care is at the average statewide DD/MI rate. For a hospital to be eligible for such reimbursement, the following criteria must be met:

- i) The hospital must document that the pre-admission screening agent has not completed the assessment, planning or discharge process.
- ii) Reimbursement is limited to a maximum of three non-acute level of care days. Reimbursement will not be made for services which were billed as acute inpatient care and denied as not being medically necessary.

d) Subacute Alcoholism and Substance Abuse Treatment Services

- 1) Subacute alcoholism and other substance abuse treatment is a covered service for clients under Title XIX (Medicaid) and for

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children 13 to or through 18 years of age in Family and Children Assistance cases in the City of Chicago.

- 2) Only acute alcoholism and substance abuse treatment services (detoxification) are covered as hospital services. Regulations regarding reimbursement for subacute alcoholism and substance abuse treatment services may be found under Sections 148.340 through 148.390.

e) Transplant Program

The Medical Assistance Program provides for payment for organ transplants only when provided by a certified transplantation center as described in Section 148.82. Payment for kidney and cornea transplants does not require enrollment as an approved transplantation center. Payment for kidney and cornea transplants is made in accordance with the appropriate methodology described in Sections 148.160, 148.170, 148.250 through 148.300, or 89 Ill. Adm. Code 149.100 and 149.150. Kidney acquisition costs shall be reimbursed in accordance with 89 Ill. Adm. Code 149.150(c)(5). Payment for bone marrow, heart, liver, pancreas, kidney/pancreas and other types of transplant procedures may be covered and reimbursed in accordance with Section 148.82 provided the hospital is certified by the Department to perform the transplant.

- 1) Inappropriate Level of Care Program--Under the inappropriate Level of Care Program, hospitals may be reimbursed for providing care to non-acute patients requiring chronic, skilled nursing when a skilled nursing facility bed is not available--For a hospital to be eligible for such reimbursement, the following criteria must be met:

- A) The hospital must document its attempt to place the patient in at least five (5) appropriate facilities, and
- B) Documentation must be submitted to the Department at the time of billing.

- 2) Reimbursement under the inappropriate level of care program is limited to services provided after the minimum number of contacts specified in subsection (b)(1)(A) above have been made--Reimbursement shall not be made for services which were billed as acute inpatient care and denied as not being medically necessary--Reimbursement shall be made for up to a maximum of 31 days before additional documentation must be submitted to extend the eligibility for additional reimbursement

Section 148.50(e) (continued)

- 3) There are two levels of care and rates associated with the program
 - A) If the patient's needs reflect routine skilled care and the inability to place the patient is due to unavailability of a skilled nursing bed, the appropriate rate shall be the average skilled statewide rate for skilled nursing care.
 - B) If the level of care required is not routinely performed within a skilled setting, such as ventilator care, and the patient cannot be placed in a skilled nursing facility because the level of care is not available, the appropriate rate is the average statewide negotiated rate for exceptional care, as described in subsection (a)(4) below.
- 4) Exceptional Care Program. -- Exceptional care is the level of medical care required by persons who are medically stable and ready for discharge from a hospital but who require a multi-disciplinary level of care for physician, nurse, and ancillary specialist services with exceptional costs related to extraordinary equipment and supplies that have been determined to be a medical necessity. -- This includes, but is not limited to, persons with Acquired Immune Deficiency Syndrome (AIDS) or a related condition, head-injured persons, and ventilator dependent persons. -- Consideration may be given to those residents currently residing in a facility who require a multi-disciplinary level of care and meet criteria as stated in 89 Ill. Adm. Code 140.569(f)(2). -- The method utilized for placement of an exceptional care person shall be as follows:
 - A) If hospital residing long-term care reimbursement is requested under the Exceptional Care Program, the discharging hospital in which the patient is located shall contact the IDPA Exceptional Care nurse assigned to their particular area.
 - B) If determined that the request for Exceptional Care is appropriate, the IDPA Exceptional Care nurse shall conduct an assessment at the hospital to determine if the patient meets Exceptional Care criteria.
 - C) If the patient is approved by the IDPA Exceptional Care nurse, the patient may be transferred to the contracting nursing facility. The transfer process is the responsibility of the hospital discharge planner or social worker. The Exceptional Care nurse shall be notified of

Section 148.50(e)(4)(C) (continued)

the date the patient has been discharged to the long-term care facility.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 148.60 Services Not Covered as Hospital Services

Certain services, although included in the Medical Assistance Program and under certain circumstances provided in the hospital setting or by an entity associated with the hospital, are not reimbursed by the Department as hospital services. In addition, certain services currently provided in the hospital outpatient and hospital-based clinic setting are subject to fee-for-service payment methodologies. This means that for these services, hospitals shall be required to conform to the policies and billing procedures in effect for other non-hospital providers of services. Payment for these services shall be based on the same fee schedule that applies to these services when they are provided in the non-hospital setting. Services not covered or reimbursed as hospital services are as follows:

- a) Private Duty Nursing Services. Hospitals may not enroll to provide private duty nursing services. Hospitals are expected to provide all required nursing services, and generally, persons requiring special nursing care are placed in an intensive care unit.
- b) Sitter Services. Sitter services for hospitalized program participants are not covered under the Medical Assistance Program.
- c) Dental Services. Hospitals may not enroll to provide dental services. When dental services are provided in the outpatient/clinic setting of a hospital, the dentist shall submit charges to the Department according to the provisions of the Dental Program.
- d) Nurse Anesthetist Services. Payment for general anesthesia services not reimbursed under 89 Ill. Adm. Code 140.400 shall be made only to hospitals that qualify for these payments under the Medicare Program (Title XII) and shall be made to such hospitals when provided by a hospital employed nonphysician anesthetist (Certified Registered Nurse Anesthetist or "CRNA").
- e) Pharmacy Services. Policy and reimbursement for pharmacy services is described in 89 Ill. Adm. Code 140.440 through 140.450. A hospital pharmacy may enroll on a fee-for-service basis for services provided to a patient in:
 - 1) A specified bed or special hospital unit which is certified for

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Section 148.60(e)(1) (continued)

skilled nursing facility services under the Medicare Program;

- 2) A special hospital unit or separate facility which is administratively associated with the hospital and is licensed as a long term care facility;
- 3) The emergency room when the services provided are not true emergency services; or
- 4) The outpatient/clinic setting when the services provided are not unique to the hospital setting.

f) Medical Transportation Services. A hospital that owns and operates medical transportation vehicles as a separate entity, e.g., a private corporation, must enroll as a medical transportation provider. A hospital that owns and operates medical transportation vehicles that are included on the hospital's cost report as a cost center of the hospital may not submit a separate claim for transportation services provided to persons admitted as inpatients. Policy and reimbursement for medical transportation services is described in 89 Ill. Adm. Code 140.490 through 140.492.

g) Home Health Services. Home health services are not considered by the Department to be hospital services. A home health agency that is administratively associated with a hospital and that is certified for participation as a home health agency by the Medicare Program may apply for participation for the provision of home health services. Policy and reimbursement for home health services is described in 89 Ill. Adm. Code 140.470 through 140.474.

h) Subacute Alcoholism and Substance Abuse Treatment Services. Only acute alcoholism and substance abuse treatment services (i.e., detoxification) are covered as hospital services. Regulations regarding reimbursement for subacute alcoholism and substance abuse treatment services may be found under Sections at-89-111-Adm.-Code 148.340 through 148.390.

i) Hospice Services. Hospice is an alternative to traditional Medicaid coverage. The Hospice Program is responsible for all the client's medical needs related to a terminal illness. If a client chooses the Hospice Program, a physician must certify that the client is terminally ill and has a life expectancy of six months or less.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

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Section 148.70 Limitation On Hospital Services

- a) Payment for inpatient hospital care in general and specialty hospitals shall be made only when it is recommended by a qualified physician and the care is essential as determined by the appropriate utilization review authority. For hospitals or distinct part units reimbursed on a per diem basis under Sections 148.160 through 148.170 and 148.250 through 148.300, payment shall not exceed the number of days approved for the recipient's care by the appropriate utilization review authority (see Section 148.240). If Medicare benefits are not paid because of non-approval by the utilization review authority, payment shall not be made on behalf of the Department.
- b) For hospitals or distinct part units reimbursed on a per case basis, payment for inpatient hospital services shall be made in accordance with 89 Ill. Adm. Code Part 149.
- c) For hospitals, or distinct part units reimbursed on a per diem basis, under Sections 148.160 through 148.170 and 148.250 through 148.300, payment for inpatient hospital services shall be made based on calendar days. The day of admission shall be counted. The day of discharge shall not be counted. An admission with discharge on the same day shall be counted as one day. If a recipient is admitted, discharged and re-admitted on the same day, only one day shall be counted.
- d) In obstetrical cases, payment for services to both the mother and the newborn child shall be made at one per diem rate, or one per case rate, whichever is applicable. Only in instances in which the medical condition of the newborn, as certified by the utilization review authority, necessitates care in other than the newborn nursery, shall payment be made in the child's name separately.
- e) Payment for inpatient psychiatric hospital care in a psychiatric hospital, as defined in 89 Ill. Adm. Code 149.50(c)(1), shall be made only when such services have been provided in accordance with federal regulations at 42 CFR Part 441, Subparts C and D. Payment for all inpatient psychiatric services is subject to a prepayment review. All prepayment review shall be conducted by the Department's designated peer review agent. Prepayment review shall be used to determine the appropriateness and necessity of the inpatient psychiatric care. Only inpatient psychiatric care medically necessary, as determined by a physician licensed to practice medicine in all its branches, will be reimbursed by the Department. The following criteria exemplify the factors that shall be used to determine the medical necessity of inpatient psychiatric care:

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Section 148.70(e) (continued)

Section 148.82(b) (continued)

- 1) The patient's condition indicates that he or she suffers from an acute psychological or physiological disorder requiring inpatient hospital intervention (including, but not limited to: acute disabling symptoms as a response to bio-psycho-social stress; acute danger to self or others; the medical necessity for interventions possible only in an inpatient hospital setting); and
- 2) A comprehensive treatment plan has been developed and progress documented for the patient (including, but not limited to: physician's progress notes; participation in medical psychotherapy; assessment of available rehabilitative resources; creation of treatment goals).

- 2) Other types of transplant procedures may be covered when a hospital has been certified by the Department as a transplant center eligible to perform such transplants. Centers must complete the certification process established in Section 148.82(c) 148-80(e) and provide the necessary documentation of the number of transplant procedures performed and the survival rates.
- 3) Medically necessary work-up and evaluation up to three (3) days prior to transplantation.

c) Certification Process

c) Certification Process

- f) Payment for transplantation transplant costs (with the exception of kidney and cornea transplants), including organ acquisition costs, shall be made only when provided by an approved transplantation center as described in Section 148.82 148-80(e)-through-(h). Payment for kidney and cornea transplantation transplant costs does not require enrollment as an approved transplantation center. Payment for kidney acquisition costs does not require enrollment as an approved transplantation center, but is only provided to hospitals reimbursed on a per case basis in accordance with 89 Ill. Adm. Code 149.

- 1) In order to be certified to receive reimbursement for transplants performed on Medicaid patients, the hospital must:
 - A) Request an application from the Bureau of Hospital Services;
 - B) Submit a completed application to the Department for the type of transplant for which the center is seeking certification;

- g) Payment for end-stage renal disease treatment shall be made only when provided to recipients who have been screened by and meet medical criteria established by the Department of Public Health.

- C) Meet certification criteria established in subsection (d) below, based upon review and recommendation of each application by the State Medical Advisory Committee (SMAC); and

- D) Submit a detailed status report on each patient for the type of transplant for which the hospital is seeking certification. Such reports must include the date of transplant, the length of hospitalization, charges, survival rates, patient-specific transplant outcome, and complications (including cause of death, if applicable) for all transplants performed for the two years preceding the date of the application. To protect the privacy of patients included in this report, names of Medicaid and non-Medicaid patients are not required.

- D) Submit a detailed status report on each patient for the type of transplant for which the hospital is seeking certification. Such reports must include the date of transplant, the length of hospitalization, charges, survival rates, patient-specific transplant outcome, and complications (including cause of death, if applicable) for all transplants performed for the two years preceding the date of the application. To protect the privacy of patients included in this report, names of Medicaid and non-Medicaid patients are not required.

Section 148.82 Organ Transplant Services

a) Introduction

The Department of Public Aid will cover organ transplants as identified under subsection (b) below which are provided by certified organ transplant centers which meet the requirements specified in subsections (c) through (h) of this Section.

- 2) The Department shall notify the hospital of approval or denial of the hospital as a transplant center for Medicaid eligible patients.

b) Covered Services

- 1) Bone Marrow, heart, liver, or pancreas/pancreas-kidney transplantation excluding bone marrow searches.

- 3) In the event that no hospital formally certified by the Department is able to provide a covered service set forth in subsection (b) above within the time frame necessary to preserve the recipient's health, the Department shall review a request

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Section 148.82(c)(3) (continued)

for prior approval of the service from a non-certified facility, and if the facility satisfies the criteria for certification, approve the request on an individual case basis.

d) Certification Criteria

- 1) Hospitals seeking certification as a transplant center shall submit documentation to verify that:

- A) The hospital is a tertiary care hospital capable of providing all necessary medical care required by the transplant patient;
- B) The hospital is affiliated with an academic health center;
- C) The hospital has had the transplant program for heart and liver transplants in operation for at least three years with twelve 12 transplant procedures per year for the past two years and twelve 12 cases before that for adult heart and liver transplants;
- D) The hospital has had the transplant program for adult and pediatric bone marrow transplants in operation for at least two years with twelve transplant procedures per year for the past two years;
- E) A hospital specializing in pediatric heart and/or liver transplants must have a program in operation for at least three years and must have performed a minimum of six transplant procedures per year for the past two years, and six before that;
- F) The hospital has had the transplant program in operation for at least three years with 25 transplant procedures per year for the past two years and 25 cases before that for kidney transplants, and five transplant procedures per year for the past two years and five before that for pancreas transplants, or twelve 12 transplant procedures per year for the past two years and twelve 12 before that for kidney/pancreas transplants;
- G) The hospital has experts, on staff, in the fields of cardiology, anesthesiology, immunology, infectious disease, nursing, social services, organ procurement, associated surgery and internal medicine to complement the transplant team. In addition, in order to qualify as a transplant

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Section 148.82(d)(1)(G) (continued)

- center for pediatric patients, the hospital must also have experts in the field of pediatrics;
- H) The hospital has an active cardiovascular medical and surgical program as evidenced by the number of cardiac catheterizations, coronary arteriograms and open heart procedures per year for heart transplant candidates;
- I) The hospital has pathology resources that are available for studying and reporting the pathological responses for transplantation;
- J) The hospital complies with applicable State and Federal laws and regulations;
- K) The hospital participates in a recognized national donor procurement program, abides by its rules, and provides the Department with the name of the national organization of which it is a member;
- L) The hospital has an interdisciplinary body to determine the suitability of candidates for transplantation;
- M) The hospital has blood bank support necessary to meet the demands of a certified transplant center; and
- N) The hospital meets the applicable transplant survival rates as supported by the Kaplan-Meier method or other method accepted by the Department:
 - i) A one-year survival rate of 50 percent for bone marrow transplant patients;
 - ii) A one-year survival rate of 75 percent and a two-year survival rate of 60 percent for heart transplant patients;
 - iii) A one-year survival rate of 75 percent and a two-year survival rate of 60 percent for liver transplant patients.
 - iv) A one-year survival rate of 90 percent for kidney transplant and a one-year survival rate of 80 percent for pancreas transplant; or a one-year survival rate of 80 percent for kidney/pancreas transplant.

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Section 148.82(d) (continued)

2) The commitment of the hospital to support the transplant center must be at all levels as evidenced by such factors as financial resources, allocation of space and the support of the professional staff for the transplant program and its patients. The hospital must demonstrate that:

- A) Component teams are integrated into a comprehensive transplant team with clearly defined leadership and responsibility;
- B) The hospital safeguards the rights and privacy of patients;
- C) The hospital has adequate patient management plans and protocols to meet the patient and hospital's needs.
- 3) The hospital must identify, in writing, the director of the transplant program and the members of the team as well as their qualifications. Physician team members must be identified as board certified, in preparation for board certification, or pending board certification, and the transplant coordinator's name must be submitted.

4) The hospital must provide patient selection criteria including indications and contraindications for the type of transplant procedure for which the facility is seeking certification.

e) Recertification Process/Criteria

1) The Department will conduct an annual review for certification of transplant centers. A certified center must submit documentation established under subsections (c), (d), (f) and (h) of this Section for review by the Department's State Medical Advisory Committee for recertification as a transplant center.

2) Survival rates of previous transplant patients must be documented prior to certification. The center must maintain patient volume in the year of certification based on previous transplant statistics.

3) The Department shall notify the hospital of approval or denial of the recertification of the hospital as a transplant center.

f) Notification of Transplant

1) The hospital must notify the Department prior to performance of the transplant procedure. The notification letter must be from a physician on the transplant team.

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Section 148.82(f) (continued)

2) The notification must include the admission diagnosis, pre-transplant diagnosis and the initial work-up summary of medical findings.

3) The Department shall notify the hospital regarding receipt of the notification and provide the appropriate "patient tracking" forms to the hospital.

g) Reimbursement

1) Hospital services rendered for transplant procedures under this Section are exempt from the provisions of Sections 148.250 through 148.330 and the 89 Ill. Adm. Code 149 of the Department's administrative rules governing hospital reimbursement. Hospital reimbursement for transplants covered within this Section is an all-inclusive rate for the admission, regardless of the number of days of care associated with that admission, which is limited to a maximum of 60 percent of the hospital's usual and customary charges to the general public for the same procedure for the number of days listed below for specific types of transplants:

- A) Three days of pre-operative inpatient work-up; and
 - B) A maximum 30 consecutive days of post-operative inpatient care for heart, pancreas, or kidney/pancreas transplant; or
 - C) 40 consecutive days of inpatient care for liver transplant; or
 - D) 50 consecutive days of inpatient care for bone marrow transplant; or
 - E) For those transplants covered under subsection (b)(2), the number of consecutive days of inpatient care specified within the transplant certification process.
- 2) Reimbursement will be approved only when the Department's letter acknowledging the notification of the transplant procedure is attached to the hospital's claim.
- 3) Applicable disproportionate share payment adjustments shall be made in accordance with Section 148.120(g). Applicable outlier adjustments shall be made in accordance with Section 148.130. Applicable inpatient payment adjustments shall be made in accordance with Section 148.290.

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Section 148.82(g) (continued)

- 4) The rate will not include transportation and physician fees when reimbursed pursuant to 89 Ill. Adm. Code 140.410 through 140.414 and 89 Ill. Adm. Code 140.490 through 140.492, respectively.

h) Reporting Requirements of Certified Transplant Center

The following documentation must be submitted within the time limits set forth in this subsection.

1) Patient Tracking

- A) The center must submit annually a statistical summary including information for all patients having received transplants at the transplant center. Patients not covered by Medicaid may be identified numerically or by other means identified by the hospital, to protect patient confidentiality. The summary must include, but is not limited to, short and long term outcome on all patients.

- B) The discharge summary for each Medicaid patient must be received by the Department within thirty 30 days of the patient's discharge.

- C) The annual outcome summaries for each Medicaid patient must be received by the Department within thirty 30 days of the annual patient post-transplant evaluation.

- D) For those Medicaid patients who expire, a summary must be received by the Department within thirty 30 days of the patient's death.

2) Notification of Changes

The center must notify the Department within thirty 30 days of any changes in its program including, but not limited to, certification criteria, patient selection criteria, members of the transplant team and the coordinator.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 148.120 Disproportionate Share Hospital (DSH) Adjustments

Disproportionate Share Hospital (DSH) adjustments for inpatient services provided prior to October 1, 1993, shall be determined and paid in accordance with the statutes and administrative rules governing the time period when the services

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were rendered. The Department shall make an annual determination of those hospitals qualified for adjustments under this Section effective October 1, 1993, and each October 1, thereafter.

- a) Qualified Disproportionate Share Hospitals (DSH). DSH adjustments for inpatient services provided prior to October 1, 1993, shall be determined and paid in accordance with the statutes and administrative rules governing the time period when the services were rendered, except as specifically indicated otherwise in this Part and with the following exception: Beginning with State Fiscal Year 1993, the annual determination of these hospitals qualifying for adjustments under this Section shall be made effective on October 1, 1993, and each October 1 thereafter. Hospitals qualified for DSH adjustments on June 30, 1993 shall continue to be eligible for such adjustments for inpatient services provided July 1, 1993 through September 30, 1993, in accordance with 89 Ill. Adm. Code 148.20(b). Hospitals located in a federally designated Health Manpower Shortage Area (42 CFR 5.198) on June 30, 1993, that would have met the criteria described in (a)(3) if such designation had been effective on July 1, 1993, shall be eligible for DSH adjustments for inpatient services provided July 1, 1993 through September 30, 1993, utilizing the payment adjustment methodologies defined in the statutes and administrative rules which were in effect on June 30, 1993. For inpatient services provided on or after October 1, 1993, October 1, 1993, the Department shall make adjustment payments to hospitals which are deemed as disproportionate share by the Department. A hospital may qualify for a DSH adjustment in one of the following ways:

- 1) The hospital's Medicaid inpatient utilization rate, as defined in subsection (1)(5) of this Section, in terms of inpatient days of care provided to Title XIX recipients compared to total inpatient days of care provided, is at least one half standard deviation above the mean Medicaid utilization rate, as defined in subsection (1)(3) of this Section. Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) and Aid to the Medically Indigent (AMI) days but does include the types of days described in subsection (e)(3) below in this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

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Section 148.120(a) (continued)

2) The hospital's low income utilization rate exceeds 25 per centum 25%. For this alternative, payments for all patient services (not just inpatient) for Medicaid, Family and Children Assistance (formerly known as General Assistance), Aid to the Medically Indigent (AMI) and/or any local or state government-funded care, must be counted as a percentage of all net patient service revenue. To this percentage, the percentage of total inpatient charges attributable to inpatient charges for charity care (less payments for GA and AMI inpatient hospital services, and/or any local or state government-funded care) must be added.

3) Illinois hospitals that, on July 1, 1991, were located in a federally designated Health Manpower Shortage Area (42 CFR 5.1989) and that had a Medicaid inpatient utilization rate, as defined in subsection (1)(5) of this Section (a)(1) above, that was at least the mean Medicaid inpatient utilization rate, as defined in subsection (1)(3) of this Section, for all hospitals in Illinois receiving Medicaid payments from the Department and which were located in a planning area with one-third or fewer excess beds as determined by the Illinois Health Facilities Planning Board (77 Ill. Adm. Code 1100), and that, as of June 30, 1992, were located in a federally designated Health Manpower Shortage Area (42 CFR 5.1989). The provisions of this subsection shall no longer apply effective on or after October 1, 1993.

4) Illinois hospitals that:

- A) Have have a Medicaid inpatient utilization rate, as defined in subsection (1)(5) of this Section (a)(1) above, which is at least the mean Medicaid inpatient utilization rate, as defined in subsection (1)(3) of this Section, for all hospitals in Illinois receiving Medicaid payments from the Department, and
- B) also have have a Medicaid obstetrical inpatient utilization rate, as defined in subsection (1)(6) of this Section, that is at least one standard deviation above the mean Medicaid obstetrical inpatient utilization rate, as defined in subsection (1)(4) of this Section for all hospitals in Illinois receiving Medicaid payments from the Department for obstetrical services.

5) Any children's hospital, which means a hospital devoted exclusively to caring for children. A hospital which includes a

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Section 148.120(a)(5) (continued)

facility devoted exclusively to caring for children that is separately licensed as a hospital by a municipality shall be considered a children's hospital to the degree that the hospital's Medicaid care is provided to children.

6) Critical-Care-Areas-(CCA)-Hospitals--CCA-Hospitals-are hospitals-reimbursed-under-Sections-148-260-through-148-200-of-80-III-Adm-Code-149-that-meet-at-least-one-of-the-following-criteria:

A) The hospital is designated, as of the first day of July preceding the DSH determination year, as a Level-III perinatal center by the Illinois Department of Public Health, is located in a rural area, and provides a disproportionate share of perinatal services.

i) For hospitals meeting the criteria in subsection (a)(6)(A) above, a disproportionate share of perinatal services shall be calculated by dividing each such hospital's Medicaid perinatal admissions by its total Medicaid admissions to arrive at the perinatal percentage.

ii) For hospitals meeting the criteria in subsection (a)(6)(A) above, these hospitals with a perinatal percentage of 30 percent or above shall be deemed to provide a disproportionate share of perinatal services.

B) The hospital is located in a rural area, as of the first day of July preceding the DSH determination year, and provided a disproportionate share of obstetrical services.

i) For hospitals meeting the criteria in subsection (a)(6)(B) above, a disproportionate share of obstetrical services shall be calculated by dividing each such hospital's Medicaid obstetrical admissions by its total Medicaid admissions to arrive at the obstetrical percentage.

ii) For hospitals meeting the criteria in subsection (a)(6)(B) above, these hospitals with an obstetrical percentage of 30 percent or above shall be deemed to provide a disproportionate share of obstetrical services.

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- b) In addition, to be deemed a DSH hospital, a hospital must provide the Department, in writing, with the names of at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This requirement does not apply to a hospital in which the inpatients are predominantly individuals under 18 years of age; or does not offer nonemergency obstetric services as of December 22, 1987. Hospitals that do not offer nonemergency obstetrics to the general public, with the exception of those hospitals described in 89 Ill. Adm. Code 149.50(c)(1) through (c)(4), must submit a statement to that effect.

- c) In making the determination described in subsections (a)(1) and (a)(4)(A) above, the Department shall utilize:

- 1) The hospital's final audited cost report for the hospital's base fiscal year. Medicaid inpatient utilization rates, as defined in subsection (1)(5) of this Section subsections-(a)(1)-and (a)(4)(A)-above, which have been derived from final audited cost reports, are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation.
- 2) In the absence of a final audited cost report for the hospital's base fiscal year, the Department shall utilize the hospital's unaudited cost report for the hospital's base fiscal year. Due to the unaudited nature of this information, hospitals shall have the opportunity to submit a corrected cost report for the determination described in subsections (a)(1) and (a)(4)(A) above. Submittal of a corrected cost report in support of subsections (a)(1) and (a)(4)(A) above must be received no later than the first day of July preceding the DSH determination year for which the hospital is requesting consideration of such corrected cost report for the determination of DSH qualification. Corrected cost reports which are not received in compliance with these time limitations will not be considered for the determination of the hospital's Medicaid inpatient utilization rate as described in subsection (1)(5) of this Section subsections-(a)(1)-and-(a)(4)(A)-above.

- A) Hospitals' Medicaid inpatient utilization rates, as defined in subsection (1)(5) of this Section subsections-(a)(1)-and-

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(a)(4)(A)-above, which have been derived from unaudited cost reports, are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation. Pursuant to subsection (c)(2) above, hospitals shall have the opportunity to submit corrected cost report information prior to the Department's final DSH determination.

- B) In the event a subsequent final audited cost report reflects a Medicaid inpatient utilization rate, as described in subsection (1)(5) of this Section subsections-(a)(1)-and-(a)(4)(A)-above, which is lower than the Medicaid inpatient utilization rate derived from the unaudited cost report utilized for the DSH determination, the Department shall recalculate the Medicaid inpatient utilization rate based upon the final audited cost report, and recoup any overpayments made.
- 3) Certain types of inpatient days of care provided to Title XIX recipients are not available from the cost report, i.e., Medicare/Medicaid crossover claims, out-of-state Title XIX Medicaid utilization levels, HMO days and inappropriate level of care days. To obtain Medicaid utilization levels in these instances, the Department shall utilize:

- A) Medicare/Medicaid Crossover Claims. The Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year. Effective with DSH-determinations-on-and-after-October-1, 1993, Hospitals may submit additional information to document Medicare/Medicaid crossover days which were not billed to the Department due to a determination that the Department had no liability for deductible and/or coinsurance amounts. This information must be submitted in log form. The log must include a patient account number or medical record number, patient name, Medicaid recipient identification number, Medicare identification number, date of admission, date of discharge, the number of covered days, and the total number of Medicare/Medicaid crossover days. This log must include all Medicare/Medicaid crossover days billed to the Department and all Medicare/Medicaid crossover days which were not billed to the Department for services provided during the hospital's base fiscal year. If a hospital does not submit a log of Medicare/Medicaid crossover days that meets the above

Section 148.120(c)(3)(A) (continued)

requirements, the Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for the hospital's applicable base fiscal year.

B) Out-of-state Title XIX Utilization Levels. Hospital statements and verification reports from other states will be required to verify out-of-state Medicaid recipient utilization levels. The information submitted must include only those days of care provided to out-of-state Medicaid recipients during the hospital's base fiscal year.

C) HMO days. The Department will shall utilize the Department's HMO claims data available to the Department as of the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of inpatient days provided to recipients enrolled in an HMO.

D) Hospital Residing Long Term Inappropriate Level-of Care Days. The Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of hospital residing long term care days provided to recipients.

d) Hospitals may apply for DSH status under subsection (a)(2) by submitting an audited certified financial statement for the hospital's base fiscal year. The audited certified financial statement must contain the following breakdown of information prior to submittal to the Department for consideration:

- 1) Total hospital net revenue for all patient services, both inpatient and outpatient, for the hospital's base fiscal year.
- 2) Total payments received directly from State and local governments for all patient services, both inpatient and outpatient, for the hospital's base fiscal year.
- 3) Total gross inpatient hospital charges for charity care (this must not include contractual allowances, bad debt or discounts, except contractual allowances and discounts for Family and Children Assistance, formerly known as General Assistance, GA and AMI patients), for the hospital's base fiscal year.
- 4) Total amount of the hospital's gross charges for inpatient hospital services for the hospital's base fiscal year.

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e) With the exception of cost-reporting children's hospitals in contiguous states that provide 100 or more inpatient days of care to Illinois program participants, only those cost-reporting hospitals that qualify for DSH in the state in which they are located based upon the Federal definition of a DSH hospital, as defined in Section 1923(b)(1) of the Social Security Act, may qualify for DSH hospital adjustments under subsections (g) and (h) of this Section. For purposes of determining the Medicaid inpatient utilization rate, as described in subsection (1)(5) of this Section and as required in Section 1923(b)(1) of the Social Security Act, out-of-state hospitals will be measured in relationship to one standard deviation above the mean Medicaid inpatient utilization rate in their state.

Out-of-state hospitals that do not qualify by the Medicaid inpatient utilization rate from their state may submit an audited certified financial statement as described in subsection (d) above. Payments to out-of-state hospitals will be allocated using the same methods as described in subsections (g) through (m).

f) Time Limitation Requirements for Additional Information.

- 1) Beginning with the October 1, 1993, DSH determination year, the information required in subsections (a)(2), (c), (d) and (e) must be received no later than the first day of July preceding the DSH determination year for which the hospital is requesting consideration of such information for the determination of DSH qualification. Information required in this section which is not received in compliance with these limitations will not be considered for the determination of those hospitals qualified for DSH adjustments.
- 2) Beginning with the October 1, 1993, DSH determination year, the information required in subsections (b) and (f)(5)(B) must be received within 30 calendar days after receipt of notification from the Department that the information must be submitted. Information required in this Section which is not received in compliance with these limitations will not be considered for the determination of those hospitals qualified for DSH adjustments.

g) Inpatient Payment Adjustments to DSH Hospitals. The adjustment payments required by subsection (a) above shall be calculated annually as follows:

- 1) Five Million Dollar Fund Adjustment

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Section 148.120(g)(1) (continued)

- A) Hospitals qualifying as DSH hospitals under subsection (a)(1) that have a Medicaid inpatient utilization rate, as described in subsection (1)(5) of this Section, which is at least one standard deviation above the mean Medicaid inpatient utilization rate, as described in subsection (1)(3) of this Section, and hospitals qualifying as DSH hospitals under subsection (a)(2) of this Section will receive an add-on payment to their inpatient rate.

- B) The distribution method for the add-on payment described in subsection (g)(1)(A) above is based upon a fund of \$5 million \$5M. All hospitals qualifying under subsection (g)(1)(A) above (a) that have a Medicaid inpatient utilization rate which is at least one standard deviation above the mean Medicaid inpatient utilization rate, and all hospitals qualifying as DSH hospitals under subsection (a)(2) will receive a five-dollar-\$5 per day add-on to their current rate. The total cost of this adjustment is calculated by multiplying each hospital's most recent completed fiscal year Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) by five-dollars-\$5. The total dollar amount of this calculation is then subtracted from the \$5 million \$5M fund.

- C) The remaining fund balance is then distributed to the hospitals that qualify under subsection (a)(1) above that have a Medicaid inpatient utilization rate, as described in subsection (1)(5) of this Section, which is at least one standard deviation above the mean Medicaid inpatient utilization rate, in proportion to the percentage by which the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the State's mean Medicaid inpatient utilization rate, as described in subsection (1)(3) of this Section. This is done by finding the ratio of each hospital's percent Medicaid utilization to the State's mean plus one standard deviation percent Medicaid value. These ratios are then summed and each hospital's proportion of the total is calculated. These proportional values are then multiplied by each hospital's most recent completed fiscal year Medicaid inpatient utilization data paid inpatient day-values (adjusted based upon historical utilization and projected increases in utilization). These weighted values are summed and each hospital's proportion of the summed weighted value is calculated. Each individual

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Section 148.120(g)(1)(C) (continued)

hospital's proportional value is then multiplied against the \$5 million \$5M pool of money available after the five dollars-\$5 per day base add-on has been subtracted.

- D) The total dollar amount calculated for each qualifying hospital under subsection (g)(1)(C) above, plus the initial five-dollars-\$5 per day add-on amount calculated for each qualifying hospital under subsection (g)(1)(B) above, is then divided by the Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) inpatient day-projections to arrive at a per day add-on value. Hospitals qualifying under subsection (a)(2), will receive the minimum adjustment of five-dollars-\$5 per inpatient day. The adjustments calculated under this subsection are subject to the adjustments described in subsections (h) and (i) and the limitations described in subsection (k) of this Section (4).
- 2) Medicaid Percentage Adjustment. In addition to the adjustment methodology described in subsection (g)(1) above, all DSH hospitals described in subsections (a)(1), (2), (3), (4), and (5) shall receive a payment adjustment which shall will be calculated annually as follows:
- A) The payment adjustment shall be calculated based upon the hospital's Medicaid inpatient utilization rate, as defined in subsection (1)(5) of this Section, (a) that and subject to subsections (h), and (i), and (j) below, as follows:
- i) Hospitals with a Medicaid inpatient utilization rate below the mean Medicaid inpatient utilization rate of 75-percent-or-above shall receive a payment adjustment of \$25 \$275;
- ii) Hospitals with a Medicaid inpatient utilization rate that is equal to or greater than the mean Medicaid inpatient utilization rate but less than one standard deviation above the mean Medicaid inpatient utilization rate of at-least-50-percent-but-less-than 75-percent, shall receive a payment adjustment of \$25 plus \$1 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds the mean Medicaid inpatient utilization rate \$175;

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Section 148.120(g)(2)(A) (continued)

iii) Hospitals with a Medicaid inpatient utilization rate that is equal to or greater than one standard deviation above the mean Medicaid inpatient utilization rate but less than 1.5 standard deviations above the mean Medicaid inpatient utilization rate of at least 40 percent, but less than 60 percent, shall receive a payment adjustment of \$40 plus \$7 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate \$160; and

iv) Hospitals with a Medicaid inpatient utilization rate that is equal to or greater than 1.5 standard deviations above the mean Medicaid inpatient utilization rate of at least 30 percent, but less than 40 percent, shall receive a payment adjustment of \$90 plus \$2 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate, \$100; and

v) Hospitals with a Medicaid inpatient utilization rate less than 30 percent shall receive a payment adjustment of \$85.

B) For county-owned hospitals, hospitals as described in Section 148.25(b)(1)(A) subsection (4), or a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), the amount calculated pursuant to subsection (g)(2)(A) above shall be increased by \$60 per day \$25.

C) For hospitals described in subsection (4) that are designated as a Level III perinatal center by the Illinois Department of Public Health, the amount calculated pursuant to subsection (g)(2)(B) above shall be increased by \$150.

D) The amount calculated pursuant to subsection (g)(2)(C) above for a hospital described in subsection (4) shall be adjusted on October 1, 1992, and on the first day of July of each year thereafter, by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost report.

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Section 148.120(g)(2) (continued)

C) The Medicaid percentage adjustment payment, calculated in accordance with this subsection (g)(2), to a hospital, other than county-owned hospitals, as described in Section 148.25(b)(1)(A), or a hospital and/or hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), shall not exceed \$155 per day for a children's hospital, as described in subsection (a)(5) of this Section, and shall not exceed \$215 per day for all other hospitals.

D) The amount calculated pursuant to subsections subsection (g)(2)(A) through (g)(2)(C) above for a hospital set described in subsection (4) shall be adjusted on October 1, 1992, and annually thereafter, by a percentage equal to the lesser of:

- i) The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent 12 month period for which data are available; or
- ii) The percentage increase in the statewide average hospital payment rate, as described in subsection (1)(8) of this Section, over the previous year's statewide average hospital payment rate.

E) The amount calculated pursuant to subsections (g)(1) and (g)(2)(A) through (g)(2)(D) above for hospitals described in Section 148.25(b)(1)(A) shall be no less than the DSH rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

F) For hospitals paid on a per diem basis and those reimbursed under 80-111-Adm-Code-148.80(g), the amount calculated pursuant to subsections (g)(1) and (g)(2)(A) through (g)(2)(D) above, as adjusted pursuant to subsections (h), and (i), and (j) below, plus any applicable amount calculated under subsections (4) and (5) of this Section shall be the inpatient payment adjustment in dollars for the applicable DSH determination year, subject to the limitations described in subsections

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Section 148.120(g)(2)(F) (continued)

(g)(2)(C) and (k) (m) of this Section, and the adjustment described in subsection (g)(2)(E) above. The adjustments calculated under subsections (g)(1) and (g)(2)(A) through (g)(2)(E) of this Section shall be paid on a per diem basis and shall be applied to each covered day of care provided.

G) For hospitals paid on a per discharge basis, the amount calculated pursuant to subsections (g)(1) and (g)(2) above, as adjusted pursuant to subsections (k) and (l) below, shall be multiplied by the hospital's average length of stay, and this sum plus any applicable amount calculated under subsections (j) and (k) of this Section shall be the inpatient payment adjustment in dollars for the applicable PSH determination year, subject to the limitations described in subsection (m) of this Section. The adjustments calculated under subsections (g)(1) and (g)(2) of this Section shall be applied to each covered discharge.

H) Inpatient Adjustor for Children's Hospitals. Hospital Inpatient Payment Adjustment. For a children's hospital hospitals, as defined in subsection (a)(5) of this Section, the payment adjustment calculated under subsection (g)(2) above Medicaid inpatient utilization rate as defined in subsection (a)(1) shall be multiplied by 2.0.

I) Inpatient Adjustor for County-Owned Hospitals County-Hospital Inpatient Payment Adjustment. For county-owned hospitals, as defined in Section 148.25(b)(1)(A), as an Illinois county hospital in a county of over 3 million in population, the payment adjustment calculated under subsection (g)(2) above Medicaid inpatient utilization rate as defined in subsection (a)(1) above shall be multiplied by 3.75 2.75.

J) Inpatient Adjustor for Hospitals Organized under the University of Illinois Hospital Act. For a hospital and/or hospitals organized under the University of Illinois Hospital Act, as defined in Section 148.25(b)(1)(B), the payment adjustment calculated under subsection (g)(2) above shall be multiplied by 3.75.

K) Targeted Access Payment (TAP) Adjustment.

L) For the period July 1, 1992 through September 30, 1993, these hospitals qualified for TAP Adjustments on June 30, 1992 shall continue to be eligible for such adjustments. The payment adjustment for the period July 1, 1992 through September 30, 1993 shall be calculated in accordance with Section

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Section 148.120(j)(1) (continued)

148.20(b)(3) Effective on or after October 1, 1992, TAP adjustments shall be determined in accordance with subsections (j)(2) through (j)(7) below.

2) Medicaid Percentage Adjustment.

A) Hospitals qualifying for DSH adjustments under subsections (a)(1), (2), (3), (4) or (5) that are reimbursed under Sections 148.250 through 148.300 or 89-111 Adm. Code 149, shall qualify for the TAP Medicaid percentage adjustment if they meet at least one of the following criteria:

i) The hospital is located in an urban area and has 500 or fewer licensed beds as determined by the Illinois Department of Public Health (IDPH). Based upon the most current IDPH published report entitled "Bed Count, Average Length of Stay, Average Daily Census and Percent Occupancy for Non-Federal Hospitals in Illinois", which is available to the Illinois Department of Public Aid in the month immediately preceding the DSH determination year, or

ii) The hospital is located in a rural area and has 300 or fewer licensed beds as determined by the Illinois Department of Public Health (IDPH). Based upon the most current IDPH published report entitled "Bed Count, Average Length of Stay, Average Daily Census and Percent Occupancy for Non-Federal Hospitals in Illinois", which is available to the Illinois Department of Public Aid in the month immediately preceding the DSH determination year, or

iii) The hospital is a children's hospital as defined in subsection (a)(5) above.

B) The TAP Medicaid percentage adjustment for eligible hospitals, as defined in subsection (j)(2)(A) above, shall be calculated based upon the eligible hospital's Medicaid inpatient utilization rate as defined in subsection (a)(1) above.

C) Eligible hospitals with a Medicaid inpatient utilization rate of 45% or above shall receive an adjustment of \$70.00 per Medicaid admission in the TAP base year and all other eligible hospitals shall receive an adjustment per Medicaid admission in the TAP base year which is calculated by

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Section 148.120(j)(2)(C) (continued)

Section 148.120(j)(3)(B)(ii) (continued)

- 3) Obstetrical-Care-Adjustment.
 - A) Hospitals that qualify for DSH adjustments under subsections (a)(1), (2), (3) or (4) are reimbursed under Sections 148.250 through 148.300 of 89-111v Adm. Code-149, provide nonemergency obstetrical services, and that have complied with the requirements of subsection (b) above, shall receive a TAP-obstetrical-care adjustment if they meet at least one of the following criteria:
 - i) The hospital is located in an urban area and has 500 or fewer licensed beds as determined by the Illinois Department of Public Health (IDPH), based upon the most current IDPH published report entitled "Bed Count, Average Length of Stay, Average Daily Census and Percent Occupancy for Non-Federal Hospitals in Illinois", which is available to the Illinois Department of Public Aid in the month immediately preceding the DSH determination year; or
 - ii) The hospital is located in a rural area and has 200 or fewer licensed beds as determined by the Illinois Department of Public Health (IDPH), based upon the most current IDPH published report entitled "Bed Count, Average Length of Stay, Average Daily Census and Percent Occupancy for Non-Federal Hospitals in Illinois", which is available to the Illinois Department of Public Aid in the month immediately preceding the DSH determination year.
 - B) The TAP-obstetrical-care adjustment for eligible hospitals as defined in subsection (j)(2)(A) above, shall include:
 - i) an adjustment of \$600.00 per Medicaid obstetrical admission in the TAP base year; and
 - ii) an additional adjustment, up to \$340.00 per Medicaid obstetrical admission in the TAP base year, based upon the hospital's obstetrical admission percentage. The obstetrical admission percentage is the ratio of the hospital's obstetrical admissions to the obstetrical admissions provided by all hospitals qualified for the

- 4) Children's-Care-Adjustment.
 - A) Hospitals shall receive a TAP-children's-care adjustment if they meet the following criteria:
 - i) The hospital qualifies for DSH adjustments under subsections (a)(1), (2), (3), (4) or (5);
 - ii) The hospital is reimbursed under 89-111v Adm. Code 148.250 through 148.300 of Part 149; and
 - iii) The hospital provides services to children (defined as under the age of 18 and which excludes obstetrical services);
 - B) The TAP-children's-care adjustment for eligible hospitals as defined in subsection (j)(4)(A) above shall be based upon the eligible hospital's children's admission percentage in accordance with subsection (j)(4)(C) below.
 - C) Eligible hospitals shall receive a TAP-children's-care adjustment of up to \$600.00 per Medicaid children's admission in the TAP base year. The adjustment shall be calculated by dividing each eligible hospital's Medicaid children's admissions in the TAP base year by each eligible hospital's total Medicaid admissions in the TAP base year to arrive at the children's admission percentage.
 - D) The hospital with the highest percentage of Medicaid children's admissions shall receive an adjustment of \$600.00 for each Medicaid children's admission in the TAP base year and all other qualifying hospitals shall receive an adjustment equal to \$600.00 multiplied by the individual hospital's children's admission percentage divided by the children's admission percentage of the hospital with the

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Section 148.120(j)(4)(D) (continued)

highest-children's-admission-percentage.

5) Ambulatory-Care-Network-Adjustment.

A) Hospitals-qualifying-for-DSH-adjustments-under-subsections (a)(1)-(3)-or-(4)-that-are-reimbursed-under-Sections 148.260-through-148.200-of-89 Ill. Adm. Code-Part-149-may qualify-for-the-TAP-ambulatory-care-network-adjustment-if they-meet-at-least-one-of-the-following-criteria:

i) The-hospital-is-located-in-an-urban-area-and-has-500 or-fewer-licensed-beds-as-determined-by-the-Illinois Department-of-Public-Health-(IDPH)-based-upon-the most-current-IDPH-published-report-entitled-"Bed Count-Average-Length-of-Stay-Average-Daily-Census and-Percent-Occupancy-for-Non-Federal-Hospitals-in Illinois"-which-is-available-to-the-Illinois Department-of-Public-Aid-in-the-month-immediately preceding-the-DSH-determination-year-or

ii) The-hospital-is-located-in-a-rural-area-and-has-300-or fewer-beds-as-determined-by-the-Illinois-Department-of Public-Health-(IDPH)-based-upon-the-most-current-IDPH published-report-entitled-"Bed-Count-Average-Length of-Stay-Average-Daily-Census-and-Percent-Occupancy for-Non-Federal-Hospitals-in-Illinois"-which-is available-to-the-Illinois-Department-of-Public-Aid-in the-month-immediately-preceding-the-DSH-determination year.

B) Hospitals-meeting-the-criteria-described-in-subsection (j)(5)(A)-above-shall-complete-and-submit-the-Ambulatory Care-Network-Questionnaire-in-order-to-be-considered-for the-TAP-ambulatory-care-network-adjustment.--To-receive-the TAP-ambulatory-care-network-adjustment,-eligible-hospitals shall-be-required-to-enter-into-an-agreement-with-the Department-which-describes-in-detail-their-involvements-in ambulatory-care,-and-includes-commitments-to-maintain operations.--Hospitals-shall-be-required-to-notify-the Department-in-advance-of-any-action-which-would-result-in-a reduction-of-20-percent-or-more-in-the-number-of-visits provided-by-hospital-operated-primary-care-clinics-or-a reduction-of-40-percent-or-more-in-the-number-of-visits provided-by-primary-care-physicians.--The-TAP-ambulatory care-network-adjustment-shall-consist-of-three-(3)-possible individual-adjustments-as-follows:

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Section 148.120(j)(5)(B) (continued)

i) Hospitals-reporting-the-following-number-of-physician office-visits-on-the-Ambulatory-Care-Network Questionnaire-shall-receive-the-following-adjustments per-total-Medicaid-admissions-in-the-TAP-base-year:

Urban-Threshold	Rural-Threshold	Adjustment
-----0-----9,999	-----0-----4,999	\$-00.00
-10,000-----40,000	-5,000-----10,000	\$125.00
-40,001-----100,000	10,001-----50,000	\$145.00
-100,001-and-over	50,001-and-over	\$165.00

ii) Hospitals-qualifying-for-an-adjustment-under subsection-(j)(5)(B)(i)-above-shall-receive-an additional-\$125.00-per-total-Medicaid-admissions-in the-TAP-base-year-if-they-have-a-formal-linkage agreement-with-city-of-Chicago-Partnerships-in-Health or-Medicaid-Partnerships.

iii) Hospitals-qualifying-for-an-adjustment-under subsection-(j)(5)(B)(i)-above-shall-receive-an additional-\$125.00-per-total-Medicaid-admissions-in the-TAP-base-year-if-they-have-a-formal-linkage agreement-with-a-Federally-Qualified-Health-Center-a County-Health-Clinic-or-a-Rural-Health-Clinic.

6) TAP-Index-Adjustment.--With-the-exception-of-adjustments calculated-in-subsections-(j)(2)-through-(j)(5)-for children's-hospitals-as-described-in-subsection-(a)(5), the-sum-of-the-adjustments-calculated-in-subsections-(j)(2) through-(j)(5)-shall-be-multiplied-by-the-following applicable-percentages,-which-are-based-upon-each hospital's-Medicaid-inpatient-utilization-rate-as-defined in-subsection-(a)(1):

A) For-those-hospitals-with-a-Medicaid-inpatient-utilization-rate of-45-percent-or-above,-the-applicable-percentage-is-10-percent.

B) For-those-hospitals-with-a-Medicaid-inpatient-utilization rate-of-at-least-25-percent-but-less-than-45-percent,-the applicable-percentage-is-50-percent.

C) For-those-hospitals-with-a-Medicaid-inpatient-utilization rate-of-less-than-25-percent,-the-applicable-percentage-is 25-percent.

Section 148.120(j) (continued)

- 2) Hospitals-eligible-for-TAP-adjustments-shall-receive-the applicable-payment-adjustments-described-in-subsection-(j)-of this-Section,-in-addition-to-any-applicable-adjustments described-in-subsections-(g)-and-(h)-of-this-Section,-subject-to the-limitations-described-in-subsection-(m)-of-this-Section. The-TAP-adjustments-shall-be-paid-to-eligible-hospitals-on-a quarterly-basis.
- k) Critical-Care-Access-(CCA)-Payment-Adjustments.--For-the-period-July 1,-1992-through-September-30,-1992,-these-hospitals-qualified-for-CCA payment-adjustments-on-June-30,-1992,-shall-continue-to-be-eligible for-such-adjustments.--The-payment-adjustment-for-the-period-July-1, 1992-through-September-30,-1992,-shall-be-calculated-in-accordance with-Section-148.20(b)(2).--Effective-on-or-after-October-1,-1992, CCA-adjustments-shall-be-determined-in-accordance-with-subsections (k)(1)-through-(k)(4)-below.
- 1) CCA-hospitals-are-these-hospitals-meeting-one-or-more-of-the criteria-described-in-subsection-(a)(6)-above.
- 2) CCA-payment-adjustments-are-determined-as-follows:
 - A) Level-II-Rural-Perinatal-Adjustment.--Hospitals-meeting-the criteria-defined-in-subsection-(a)(6)(A)-shall-receive-an adjustment-of-\$825.00-per-Medicare-perinatal-admission-in the-CCA-base-year.
 - B) Rural-Obstetrical-Adjustment.--Hospitals-meeting-the criteria-defined-in-subsection-(a)(6)(B)-shall-receive-an adjustment-of-\$675.00-per-Medicare-obstetrical-admission-in the-CCA-base-year.
 - 3) Hospitals-qualifying-as-DSH-hospitals-under-subsections-(a)(1), (2),-(3),-(4)-or-(5)-of-this-Section-that-also-qualify-as-CCA hospitals-under-subsection-(a)(6)-of-this-Section-shall-receive the-applicable-payment-adjustments-described-in-subsection-(h) of-this-Section-in-addition-to-any-applicable-adjustments described-in-subsections-(g)-and-(j)-of-this-Section,-subject-to the-limitations-described-in-subsection-(m)-of-this-Section. The-CCA-payment-adjustments-shall-be-paid-to-eligible-hospitals on-a-quarterly-basis.
 - 4) Hospitals-that-qualify-as-DSH-hospitals-solely-under-subsection (a)(6)-above-shall-not-be-eligible-for-any-adjustments-described in-subsections-(g) through-(j).--The-CCA-payment-adjustments shall-be-paid-to-eligible-hospitals-on-a-quarterly-basis.

Section 148.120 (continued)

- 1) DSH-Uncompensated-Care-Payment-Adjustment
 - i) The-Department-shall-make-disproportionate-share-uncompensated care-payments-to-hospitals-described-in-subsections-(a)(1) through-(a)(6)-above-that-are-reimbursed-under-Sections-148.170, 148.250-through-148.300-and-89-III-Adm.-Code-149-in-accordance with-this-subsection.
 - 2) For-the-period-August-1,-1991-through-July-31,-1992,-the hospital's-uncompensated-care-payment-shall-be-calculated-and paid-in-accordance-with-the-statutes-and-administrative-rules governing-the-time-period-when-the-services-were-rendered.
 - 3) As-a-condition-of-eligibility-for-an-uncompensated-care-payment adjustment-during-the-August-1,-1991,-uncompensated-care-rate year,-each-hospital-shall-submit,-on-or-before-January-15,-1992, the-following-inpatient,-outpatient-and-hospital-based-clinic service-information-to-the-Department-for-the-period-August-1, 1990-through-July-31,-1991:
 - A) The-dollar-amount-of-uncompensated-care-charges-rendered-in the-period-described-above.
 - B) The-dollar-amount-of-charges-rendered-during-this-period reimbursed-by-the-Department-under-General-Assistance (Article-VI-of-the-Public-Aid-Code)-or-Aid-to-the-Medically Indigent-(Article-VII-of-the-Public-Aid-Code).
 - C) The-dollar-amount-of-Medicare-charges-rendered-in-the period-described-above.
 - D) The-dollar-amount-of-total-charges-for-care-rendered-in-the period-described-above.
 - 4) For-the-period-August-1,-1992-through-September-30,-1992,-the hospital's-uncompensated-care-payment-shall-be-calculated-in accordance-with-89-III-Adm.-Code-148.20(b).--This-payment-is contingent-upon-the-Department's-acceptance-of-the-data-described in-subsection-(1)(2)-above-in-accordance-with-the-time limitation-described-in-subsection-(1)(3)-above.
- k) DSH Adjustment Limitations.
 - 1) Hospitals that qualify for DSH adjustments under subsections-(a) through-(k)-of this Section shall not be eligible for the total DSH adjustment if, during the DSH determination year, the +

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A) The hospital discontinues the provision of non-emergency obstetrical care (the provisions of this subsection shall not apply to those hospitals described in 89 Ill. Adm. Code 149.50(c)(1) through (c)(4) or those hospitals that have not offered nonemergency obstetric services as of December 22, 1987). In this instance, the total DSH adjustments shall be reduced as follows:

i) The adjustments calculated under subsections (g)(1) and (g)(2) shall cease effective on the date that the hospital discontinued the provision of such non-emergency obstetrical care.

ii) ~~The adjustments calculated under subsections (j) and (k) of this Section shall be pro-rated based upon the date that the hospital discontinued the provision of non-emergency obstetrical care.~~

B) ~~The hospital does not honor its commitment to maintain operations as required in subsection (j)(5)(B) of this Section. In the event that there is a reduction of 20 percent or more in the number of visits provided by hospital-operated primary care clinics or a reduction of 20 percent or more in the number of visits provided by primary care physicians, the Department may, subject to approval by the Director, deem the hospital ineligible for the adjustments described in subsection (j)(5)(B) of this Section, either in total or in part.~~

C) ~~The hospital discontinues its formal linkage agreements required in subsections (j)(5)(B)(ii) and (j)(5)(B)(iii). In this instance, the annual adjustment described in subsection (j)(5)(B) shall be pro-rated based upon the date that the formal linkage agreement(s) was discontinued.~~

D) ~~The hospital is no longer recognized or designated by the Illinois Department of Public Health as a Level II perinatal center, as required by subsection (a)(6)(A). In this instance, the annual adjustment described in subsection (j)(5)(A) shall be pro-rated, as applicable, based upon the date that the designation ceased.~~

2) Inpatient Payment Adjustments based upon DSH Determination Reviews. Appeals based upon a hospital's ineligibility for DSH payment adjustments, or their payment adjustment amounts, in accordance with Section 148.310(b) 148.310, which result in a

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Section 148.120(l)(2) (continued)

change in a hospital's eligibility for DSH payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the DSH status of any other hospital or the payment adjustment amount of any other hospital that has received notification from the Department of their eligibility for DSH payment adjustments based upon the requirements of this Section.

3) DSH Payment Adjustment Cap. In accordance with Public Law 102-234, if the aggregate DSH payment adjustments calculated under this Section exceed the State's final DSH Allotment as determined by the Health Care Financing Administration (HCFA), DSH payment adjustments calculated under this Section shall be adjusted in proportion to the lesser State DSH Allotment.

1) Inpatient Payment Adjustment Definitions. The definitions of terms used with reference to calculation of the inpatient payment adjustments are as follows:

1) "Base fiscal year" means, for example, the hospital's fiscal year ending in 1991 for the October 1, 1993 1990-for-the-October 1-1992 DSH determination year, the hospital's fiscal year ending in 1992 for the October 1, 1994 1991-for-the-October-1-1993 DSH determination year, etc.

2) "CCA-base-year" means, State Fiscal Year 1991-for-CCA-payments calculated-for-the-October-1-1992-DSH-determination-year, State Fiscal Year 1992-for-CCA-payments-calculated-for-the-October-1-1993-DSH-determination-year, etc.

3) "Children's admission" means a claim billed as an admission of an individual under the age of 18, which was subsequently paid by the Department and contained within the Department's paid claims data base, but excludes those claims billed as admissions with an ICD-9-CM principal diagnosis code within the range of 650 and 669 (indicating an obstetrical admission).

2)4) "DSH determination year" means, beginning October 1, 1993, the 12 month period beginning on October 1 of the year and ending September 30 of the following year.

3)5) "Mean Medicaid inpatient utilization rate" means a fraction, the numerator of which is the total number of inpatient days provided in a given 12-month period by all Medicaid-participating Illinois hospitals to patients who, for such days, were eligible for Medicaid under Title XIX of the Federal Social Security Act (42 U.S.C. Sec. 1396a et seq.), and

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Section 148.120(1) (continued)

12) "Perinatal admission" means those claims billed as admissions, which were subsequently paid by the Department and contained within the Department's paid claims data base, for infants less than 49 days of age at the time of the admission with an ICD-9-CM diagnosis code within the ranges of 760 through 779 and V30 through V39, and those claims billed as admissions, which were subsequently paid by the Department and contained within the Department's paid claims data base, related to pregnancy, childbirth, and the puerperium with an ICD-9-CM principal diagnosis code within the range of 630 through 676.

13) "TAP base year" means State Fiscal Year 1991 for TAP payments calculated for the October 1, 1992 DSH determination year, State Fiscal Year 1992 for TAP payments calculated for the October 1, 1993 DSH determination year, etc.

14) "Total charges" means the total amount of a hospital's charges for inpatient, outpatient, and hospital-based clinic services, as provided.

8) "Statewide average hospital payment rate" means the hospital's alternative reimbursement rate, as defined in Section 148.270(a).

9) 15) "Total Medicaid (Title XIX) inpatient days", as referred to in subsections (1)(4) and (1)(6) above, means hospital inpatient days, excluding days for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year billed and reimbursed by the Department, and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, and specifically excludes Medicare/Medicaid crossover claims.

10) "Medicaid obstetrical inpatient utilization rate base year" means, for example, state fiscal year 1992 for the October 1, 1993, DSH determination year; state fiscal year 1993 for the October 1, 1994, DSH determination year, etc.

16) "Total medical assistance admissions" means the total claims billed as admissions which were subsequently paid by the Department and contained within the Department's paid claims data base.

17) "Uncompensated care base fiscal year" means, for example, State Fiscal Year 1991 for the October 1, 1993, uncompensated care

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Section 148.120(1)(17) (continued)

rate year, State Fiscal Year 1993, for the October 1, 1993, uncompensated care rate year, etc.

18) "Uncompensated care base year" means August 1 through July 31 of each year beginning with the initial August 1, 1990, through July 31, 1993, base year.

19) "Uncompensated care charges" for a hospital means:

A) the hospital's charges for inpatient, outpatient, and hospital-based clinic services for which the hospital was not reimbursed by either the patient or a third party (including the Department);

B) less:

i) the amount of the hospital's bad debt recoveries for inpatient, outpatient, and hospital-based clinic services; and

ii) the hospital's charges attributable to inpatient, outpatient, and hospital-based clinic services that it provided without charge or at reduced charges under its obligation under the Federal Hill-Burton Act (42 U.S.C. 201 et seq.).

20) "Uncompensated care rate year" means October 1 through September 30 of each year beginning with the October 1, 1993, rate year.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 148.130 Outlier Adjustments for Exceptionally Costly Stays

a) Outlier Adjustments. Outlier adjustments are provided for exceptionally costly stays provided by hospitals or distinct part units reimbursed on a per diem basis or hospitals reimbursed in accordance with Section 148.82(g), 89-III-Adm. Code-148-80(g) prior to October 1, 1993, shall be determined and paid in accordance with the statutes and administrative rules governing the time period when the services were rendered with the following exception: beginning with State Fiscal Year 1993, the annual determination of those hospitals qualifying for adjustments under subsection (b) below shall be made effective on October 1, 1992 and each October 1 thereafter. Hospitals qualified for outlier adjustments on June 30, 1992, shall continue to be eligible for such outlier adjustments for inpatient-

Section 148.130(a)(2) (continued)

services provided July 1, 1992, through September 30, 1992, at the adjustment rate, and utilizing the adjustment criteria in effect on June 30, 1992.

- b) The determination of those services qualified for an outlier adjustment shall be made as follows for services provided on and after October 1, 1992, and for each subsequent rate period as defined in Section 148.25(g)(2)(B), for hospitals or distinct part units reimbursed on a per diem basis or hospitals reimbursed in accordance with Section 148.82(g) 89-111-Adm-Code-148-80(g):
 - 1) The services must have been provided on or after October 1, 1992; and
 - 2) The services must have been provided to:
 - A) Children who have not attained the age of six (6) years by hospitals defined by the Department as DSH hospitals under Section 148.120(a) 148-120(a)(1)-through-(a)(6); or
 - B) Infants who have not attained the age of one (1) year by hospitals that do not meet the definition of a DSH hospital under Section 148.120(a) 148-120(a)(1)-through-(a)(6).
 - 3) Claims with total covered charges equal to or above the mean total covered charges plus one standard deviation shall be considered for outlier adjustments once the following calculations have been performed:
 - A) Total covered charges equal to or exceeding one standard deviation above the mean shall be multiplied by the hospital's cost to charge ratio.
 - B) The hospital's rate for services provided on the claim shall be multiplied by the number of covered days on the claim.
 - C) The product of subsection (3)(B) above shall be subtracted from the product of (A) above.
 - D) The difference of subsection (3)(C) above shall be multiplied by .25, the product of which shall be the outlier adjustment for the claim.
 - E) Third party payments (credits) shall be applied to the final payment made on the claim.

Section 148.130 (continued)

- c) The determination of those services qualified for an outlier adjustment shall be made in accordance with 89 Ill. Adm. Code 149.105 for hospitals reimbursed on a per case basis.
- d) Definition of terms relating to outlier adjustments are as follows:
 - 1) "Base fiscal year" means the hospital's fiscal year cost report most recently audited by the Department.
 - 2) "Cost to Charge Ratio" means the hospital's Medicaid total allowable cost for all care divided by the Medicaid total covered charges for all care. The Cost to Charge Ratio is derived by utilizing cost report data from the hospital's base fiscal year.
 - 3) "Mean total covered charges" means the mean total covered charges (as described in subsection (5) below), for services provided in the most recent state fiscal year for which complete information is available and previous rate-period which have been adjudicated paid by the Department, as follows:
 - A) For hospitals that do not meet the definition of a DSH hospital under Section 148.120(a) 148-120(a)(1)-through-(a)(6) in the DSH determination year, the mean total covered charges for all claims for inpatient services provided to individuals under the age of one year; and
 - B) For hospitals defined by the Department as DSH hospitals under Section 148.120(a) 148-120(a)(1)-through-(a)(6) in the DSH determination year, the mean total covered charges for all claims for inpatient services provided to individuals under the age of six years.
 - 4) "Rate for services provided" means the inpatient rate in effect for the type of services provided.
 - 5) "Total covered charges" means the amount entered on the UB-82 or UB-92 Uniform Billing Form for revenue code 001 in column 53 (Total Charges), minus the amount in column 54 (Non Covered Charges) for revenue code 001.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

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Section 148.140 Hospital Outpatient and Hospital-Based-Clinic Services

a) Fee-For-Service Reimbursement

- 1) Reimbursement for hospital outpatient and hospital-based clinic services shall be made on a fee for service basis, except for:

A) Those these services that meet the definition of the Hospital Ambulatory Care Program as described in subsection (b) of this Section, and except as described in subsection (a) for ESRDT services and subsection (e) for encounter-rate hospitals, which shall be reimbursed in accordance with subsections (b)(4) and (b)(5) of this Section, and adjusted in accordance with subsection (b)(7) of this Section;

B) ESRDT services, as described in subsection (c) of this Section, which shall be reimbursed in accordance with subsection (c) of this Section, and adjusted in accordance with subsection (c)(5) of this Section; and

C) Those services provided by a Certified Pediatric Ambulatory Care Center (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D), which shall be reimbursed in accordance with 89 Ill. Adm. Code 140.464(b).

2) Fee-for-service reimbursement levels shall be at the lower of the hospital's usual and customary charge to the public or the Department's statewide maximum reimbursement screens. Hospitals will be required to bill the Department utilizing specific service codes. However, all specific client coverage policies (relating to client eligibility and scope of services available to those clients) which pertain to the service billed are applicable to hospitals in the same manner as to non-hospital providers who bill fee for service.

3) With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rate described in subsection (a)(2) above shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:

A) The reimbursement rates described in subsection (a)(2) above shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.

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Section 148.140(a)(3) (continued)

B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

4) Healthy Moms/Healthy Kids rates, as described in 89 Ill. Adm. Code 140 Table M, shall be paid to Certified Hospital Ambulatory Primary Care Centers (CHAPCC), as described in 89 Ill. Adm. Code 140.461(f)(1)(A) and Section 148.25(b)(5)(A), Certified Hospital Organized Satellite Clinics (CHOSC), as described in 89 Ill. Adm. Code 140.461(f)(1)(B) and Section 148.25(b)(5)(B), and Certified Obstetrical Ambulatory Care Centers (COBACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(C), and Section 148.25(b)(5)(C). Healthy Moms/Healthy Kids rates shall also be paid to Certified Pediatric Ambulatory Care Centers (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D), for covered services as described in 89 Ill. Adm. Code 140.462(e)(3), that are provided to non-assigned Healthy Moms/Healthy Kids program clients, as described in 89 Ill. Adm. Code 140.464(b)(1).

5) Certified Pediatric Ambulatory Care Centers (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D), shall be reimbursed in accordance with 89 Ill. Adm. Code 140.464(b)(2) for assigned clients.

6) Hospitals described in Sections 148.25(b)(2)(A) and 148.25(b)(2)(B), shall be required to submit outpatient cost reports to the Department within 90 days of the close of the facility's fiscal year.

7) With the exception of the retrospective adjustment described in subsection (a)(3) above, no year-end reconciliation is made to the reimbursement rates calculated under this Section.

b) Hospital Ambulatory Care Program

Effective April 1, 1986, the Department liberalized the list of allowable ambulatory procedures to add many surgical, diagnostic and highly technical treatment procedures that can be performed and reimbursed on an ambulatory basis. Reimbursement-for-the-fee-codes established July 1, 1983, and implemented through March 31, 1986, for procedures performed in a hospital setting will be calculated and paid in accordance with the statutes and administrative rules governing the time period in question.

1) Hospital Ambulatory Care Groupings

Section 148.140(b)(1) (continued)

Under the Hospital Ambulatory Care Program, a Hospital Ambulatory Care list was developed that defines those technical procedures that require the use of the hospital outpatient or hospital-based clinic setting, its technical staff and/or equipment. These procedures were separated into four separate groupings based upon the complexity and historical costs of the procedures. The four separate groupings are as follows:

- A) Group I procedures are high level technology surgeries that consume many hospital resources and are costly to deliver.
- B) Group II procedures are certain nonsurgical, very high level technology services recognized and approved by the Department as safe outpatient procedures.
- C) Group III procedures are other surgical, specialized cardiac and diagnostic procedures.
- D) Group IV procedures are specialized treatment procedures, observation services and emergency room services.

2) Hospital Ambulatory Care List Updating

The Hospital Ambulatory Care List is updated periodically. As technology changes, so do the procedures that fall into the four categories. In addition, annual changes in the ICD-9-CM procedure codes and their meanings necessitate annual changes to the Hospital Ambulatory Care list.

3) Hospital Ambulatory Care Reimbursement Prior to October 1, 1993

Reimbursement for Hospital Ambulatory Care procedures was initially developed in 1986. For each of the four separate groupings identified in subsection (b)(1) above, a set rate maximum has been developed based upon the complexity of the procedures, historical costs, and teaching status of the hospital, the type of hospital, and the setting in which the procedure would most likely be performed (i.e., outpatient department, general clinic department, psychiatric clinic department, or physical rehabilitation clinic department). These set rate maximums have been periodically adjusted since 1986 based upon the above factors. Reimbursement for Hospital Ambulatory Care procedures performed prior to October 1, 1993, shall be reimbursed in accordance with the statutes and administrative rules governing the time period when the services were rendered.

Section 148.140(b) (continued)

4) Hospital Ambulatory Care Reimbursement Effective October 1, 1993
Effective October 1, 1993, reimbursement for Hospital Ambulatory Care procedures shall be as follows:

3) A Hospital Ambulatory Care list defines those technical procedures that require the use of the hospital outpatient or clinic setting, its technical staff and/or equipment. This list is updated periodically. The procedures are grouped according to type and complexity, each with a separate rate structure as follows:

- A) With respect to Group I procedures described in subsection (b)(1)(A) above, reimbursement shall be High-level technology surgeries are reimbursed at the lesser of charges or the hospital's alternate reimbursement rate, as defined in Section 148.270(a), equivalent to the rate of a one-day inpatient stay.
- B) With respect to Group II procedures described in subsection (b)(1)(B) above, reimbursement shall be Certain non-surgical, very high-level technology services recognized and approved by the Department as safe outpatient procedures are reimbursed in a category separate from other specialized cardiac and diagnostic procedures and are reimbursed at the lesser of charges or one of two separate rate maximums depending upon whether the hospital is classified as:
 - i) A children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3), or a major teaching hospital, as defined in Section 148.25(d), or a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3) or
 - ii) With the exception of a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3), a hospital defined in Section 148.25(e) through (f).
- C) With respect to the Group III procedures described in subsection (b)(1)(C) above, reimbursement shall be other surgical specialized cardiac and diagnostic procedures will be reimbursed at the lesser of charges or one of two separate rate maximums depending upon whether the hospital is classified as:

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- i) A a-children's-hospital-as-defined-in-89-III-Adm-Code-149.50(e){3}-or-a-major-teaching-hospital, as defined in Section 148.25(d), or a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c){3}; or
 - ii) with-the-exception-of-a-children's-hospital-as defined-in-89-III-Adm-Code-149.50(e){3}-a A hospital defined in Section 148.25(e) through (f).
- D) With respect to the Group IV procedures described in subsection (b)(1)(D) above, reimbursement shall be specialized-treatment-procedures-observation-services, high-risk-and-emergency-room-services-will-be-reimbursed at the lesser of charges or a set-rate-maximum, or one of six two separate rate maximums depending upon whether the hospital is classified as:
- i) A a-children's-hospital-as-defined-in-89-III-Adm-Code-149.50(e){3}-or-a-major-teaching-hospital, as defined in Section 148.25(d), or a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c){3}; or
 - ii) with-the-exception-of-a-children's-hospital-as defined-in-89-III-Adm-Code-149.50(e){3}-a A hospital defined in Section 148.25(e) through (f); and
 - iii) Whether whether the service is provided in the outpatient, general clinic, psychiatric clinic, or physical rehabilitation clinic department.

5) Outpatient Indigent Volume Adjustment

Effective with outpatient services provided on or after October 1, 1993, the Department shall make outpatient indigent volume adjustment payments to the amounts reimbursed under subsections (b)(4)(B) through (b)(4)(D) of this Section to a cost-reporting hospital, as described in Section 148.210(a), other than to those hospitals described in Sections 148.25(b)(2)(A), 148.25(b)(2)(C) or 148.25(b)(3), subject to the provisions of subsection (b)(5)(C) below. The outpatient indigent volume adjustment payments shall be in addition to the amounts reimbursed under subsections (b)(4)(B) through (b)(4)(D) above.

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Section 148.140(b)(5) (continued)

- A) Outpatient indigent volume adjustment payments shall be calculated by multiplying the payment to be made by the Department in accordance with subsections (b)(4)(B) through (b)(4)(D) above by the sum of the hospital's outpatient indigent volume factor and 1.00.
- B) A hospital's outpatient indigent volume factor shall be calculated annually as follows:
 - i) The hospital's Medicaid inpatient utilization rate, as described in subsection (b)(5)(D)(ii) of this Section, shall be added to the hospital's uncompensated care utilization rate.
 - ii) The sum of the calculation described in subsection (b)(5)(B)(i) above shall be multiplied by 0.5.
- C) In order to be eligible for outpatient indigent volume adjustment payments, a hospital must submit the data required under Section 148.150 in accordance with the requirements of Section 148.150.
 - i) As a condition of eligibility for an outpatient indigent volume adjustment for outpatient services provided on or after October 1, 1993, and on or before December 31, 1993, hospitals that did not comply with the data requirement described in Section 148.150(c) shall be required to submit, on or before October 1, 1993, the data required under Section 148.150(d).
 - ii) Subject to the provisions of subsection (b)(5)(C)(iii) below, a hospital that did not comply with the requirements of subsection (b)(5)(C)(i) above on or before October 1, 1993, shall not be eligible for outpatient services provided on or after October 1, 1993, and on or before September 30, 1994.
 - iii) Notwithstanding the provisions of subsections (b)(5)(C)(ii) above, a hospital that has failed to comply with the requirements of subsection (b)(5)(C)(i) above on or before October 1, 1993, but does comply with such requirements on or before November 5, 1993, shall be ineligible for outpatient indigent volume adjustments for outpatient services provided on or before October 1, 1993, and on or before December 31, 1993, but shall be eligible for

Section 148.140(b)(5)(C)(iii) (continued)

outpatient indigent volume adjustments for outpatient services provided on or after January 1, 1994, and on or before September 30, 1994.

iv) Effective with outpatient services provided on or after October 1, 1994, as a condition of eligibility for outpatient indigent volume adjustments, hospitals that did not comply with the data requirement described in Section 148.150(c) shall be required to submit, by the first day of October of each year, the data described in 148.150(c) in addition to the data required under 148.150(d). A hospital that does not comply with these data requirements by the first day of October of each year shall be ineligible for outpatient indigent volume adjustments for the rate period.

D) Outpatient Indigent Volume Adjustment Definitions. The definitions of terms used with reference to calculation of the outpatient indigent volume adjustments are as follows:

- i) "Base fiscal year" means, for example, the hospital's fiscal year ending in 1991 for the October 1, 1993, outpatient indigent volume determination year; the hospital's fiscal year ending in 1992 for the October 1, 1994, outpatient indigent volume determination year; etc.
- ii) "Medicaid inpatient utilization rate" means the percent of Medicaid inpatient utilization as determined in accordance with Section 148.120.
- iii) "Rate period" means, for dates of service on or after October 1, 1993, the 12 month period beginning on October 1 of the year and ending on September 30 of the following year.
- iv) "Uncompensated care base year" means August 1 through July 31 of each year beginning with the initial August 1, 1990, through July 31, 1991, base year.
- v) "Uncompensated care utilization rate" means the percent of uncompensated care determined in accordance with Section 148.150 in the uncompensated care base year.

Section 148.140(b) (continued)

6) No Year-End Reconciliation

With the exception of the retrospective rate adjustment described in subsection (d)(7) of this Section, no year-end reconciliation is made to the reimbursement rates calculated under this subsection (b).

7) Rate Adjustments

With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rates described in subsection (b)(4) above shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:

- A) The reimbursement rates described in subsection (b)(4) above shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.
- B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
- 8) Services are available to all clients in geographic areas in which an encounter rate hospital or a county-operated outpatient facility is located. All specific client coverage policies (relating to client eligibility and scope of services available to those clients) which pertain to the service billed are applicable to hospitals reimbursed under the Ambulatory Care Program in the same manner as to encounter rate hospitals and to non-hospital and hospital providers who bill and receive reimbursement on a fee-for-service basis.
- 9) Hospitals described in Sections 148.25(b)(2)(A) and 148.25(b)(2)(B) shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.
- 4) A list of restricted inpatient procedures pursuant to Section 148.180(b) has been established and is updated periodically. These restricted inpatient procedures will only be reimbursed when performed outside the inpatient setting or when the hospital supplies justification for an inpatient admission that-

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Section 148.140(b)(4) (continued)

- meets-Departmental-established-criteria.--These-criteria include-but-are-not-limited-to:
- A) Presence-of-medical-conditions-which-make-prolonged post-operative-observations-by-a-nurse-or-skilled-medical personnel-a-necessity-(e.g.,-heart-disease,-severe diabetes).
 - B) An-unrelated-procedure-is-being-done-simultaneously-which itself-requires-surgical-hospitalization.
 - C) The-patient-is-unable-to-comprehend-and/or-follow-the necessary-instruction-both-prior-to-and-following-the procedure-due-to-mental-and/or-physical-impairment,-and this-would-result-in-inadequate-treatment-and-place-the patient-at-risk.
 - D) Emergency-admission-or-recent-onset-of-severe-symptoms would-prohibit-safely-performing-the-procedure-on-an outpatient-basis-(e.g.,-bleeding,-severe-pain,-nausea,- vomiting).
 - E) Admission-occurs-subsequent-to-the-performance-of-the procedure-on-an-outpatient-basis-due-to-conditions-such-as:
 - i) instability-of-vital-signs
 - ii) respiratory-distress-greater-than-existed pre-operatively
 - iii) post-operative-pain-not-relieved-by-oral-medication
 - iv) uncontrolled-bleeding
 - v) lack-of-state-of-consciousness-appropriate-to-age-and development
 - vi) presence-of-persistent-nausea-or-vomiting
 - vii) inability-to-ambulate-consistent-with-age,-previous mobility-status-and/or-procedure.

c) b) Payment for outpatient end-stage renal disease treatment (ESRDT) services provided pursuant to Section 148.40(c) 148.40(a)(3) shall be made at the Department's payment rates, as follows:

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Section 148.140(c) (continued)

- 1) For inpatient hospital services services provided pursuant to Section 148.40(c)(1) 148.40(a)(3)(A), the Department shall reimburse hospitals pursuant to Sections 148.240 through 148.300 and 89 Ill. Adm. Code 149.
- 2) For outpatient services or home dialysis treatments provided pursuant to Sections 148.40(c)(2) or 148.40(c)(3) 148.40(a)(3)(B)-or-(c), the Department will reimburse hospitals and clinics for ESRDT services at a rate which will reimburse the provider for the dialysis treatment and all related supplies and equipment, as defined in 42 CFR 405.231(o) (1984). This rate will be that rate established by Medicare pursuant to 42 CFR 405.439 and 405.441 (1989).
- 3) Payment for non-routine services. For services which are provided during outpatient or home dialysis treatment pursuant to Sections 148.40(c)(2) or 148.40(c)(3) 148.40(a)(3)(B)-or-(c) but are not defined as a routine service under 42 CFR 405.231(o) (1989), separate payment will be made to independent laboratories, pharmacies, and medical supply providers pursuant to 89 Ill. Adm. Code 140.430 through 140.434, 140.440 through 140.450, and 140.475 through 140.481, respectively.
- 4) Payment for physician services relating to ESRDT will be made separately to physicians, pursuant to 89 Ill. Adm. Code 140.400.
- 5) With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rates described in this subsection (c) shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:
 - A) The reimbursement rates described in this subsection (c) shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.
 - B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
- 6) With the exception of the retrospective rate adjustment described in subsection (c)(5) above, no year-end reconciliation is made to the reimbursement rates calculated under this subsection (c).

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Section 148.140(c) (continued)

- 7) Hospitals described in Sections 148.25(b)(2)(A) and 148.25(b)(2)(B) shall be required to submit outpatient cost reports to the Department within 90 days of the close of the facility's fiscal year.
- d) Non Hospital-Based Clinic Reimbursement
- 1) County-Operated Outpatient Facility Reimbursement
- Reimbursement for all services provided by county-operated outpatient facilities, as described in Section 148.25(b)(2)(C) that do not qualify as Healthy Moms/Healthy Kids managed care clinics, as described in 89 Ill. Adm. Code 140.461(f), shall be on an all-inclusive per encounter rate basis as follows:
- A) Base Rate. The per encounter base rate shall be calculated as follows:
- i) Allowable direct costs shall be divided by the number of direct encounters to determine an allowable cost per encounter delivered by direct staff.
 - ii) The resulting quotient, as calculated in subsection (d)(1)(A)(i) above, shall be multiplied by the Medicare allowable overhead rate factor to calculate the overhead cost per encounter.
 - iii) The resulting product, as calculated in subsection (d)(1)(A)(ii) above, shall be added to the resulting quotient, as calculated in subsection (d)(1)(A)(i) above to determine the per encounter base rate.
 - iv) The resulting sum, as calculated in subsection (d)(1)(A)(iii) above, shall be the per encounter base rate.
- B) Supplemental Rate
- i) The supplemental service cost shall be divided by the total number of direct staff encounters to determine the direct supplemental service cost per encounter.
 - ii) The supplemental service cost shall be multiplied by the allowable overhead rate factor. The allowable overhead rate factor is calculated by dividing the product derived in subsection (d)(1)(B)(ii) above by

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Section 148.140(d)(1)(B)(ii) (continued)

- the quotient derived in subsection (d)(1)(B)(i) above.
- iii) The quotient derived in subsection (d)(1)(B)(i) above, shall be added to the product derived in subsection (d)(1)(B)(ii) above, to determine the per encounter supplemental rate.
- iv) The resulting sum, as described in subsection (d)(1)(B)(iii) above, shall be the per encounter supplemental rate.
- C) Final Rate
- i) The per encounter base rate, as described in subsection (d)(1)(A)(iv), shall be added to the per encounter supplemental rate, as described in (d)(1)(B)(iv), to determine the per encounter final rate.
 - ii) The resulting sum, as determined in subsection (d)(1)(C)(i) above, shall be the per encounter final rate.
 - iii) The per encounter final rate, as described in subsection (d)(1)(C)(ii) above, shall be adjusted in accordance with subsection (d)(2) below.
- 2) Rate Adjustments
- Rate adjustments to the per encounter final rate, as described in subsection (d)(1)(C)(iii) above, shall be calculated as follows:
- A) The reimbursement rates described in subsections (d)(1)(A) through (d)(1)(C) of this Section shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
- B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs

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Section 148.140(d)(2)(B) (continued)

by the total allowable Medicaid days.

- 3) County-operated outpatient facilities, as described in Section 148.25(b)(2)(C), shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year. No year-end reconciliation is made to the reimbursement calculated under this subsection (d).
- 4) Services are available to all clients in geographic areas in which an encounter rate hospital or a county-operated outpatient facility is located. All specific client coverage policies (relating to client eligibility and scope of services available to those clients) which pertain to the service billed are applicable to encounter rate hospitals in the same manner as to hospitals reimbursed under the Ambulatory Care Program and to non-hospital and hospital providers who bill and receive reimbursement on a fee-for-service basis.
- e) Reimbursement for encounter rate hospital-outpatient-and hospital-based clinic services is on a fee-for-service basis except for those services that meet the definition of the Hospital Ambulatory Care Program as described in subsection (e)(4) and except as described in subsection (b) for ESDT Services, subsection (e)(5) for encounter rate hospitals described in Section 148.25(b)(2)(B), and subsection (e)(6) for county-operated outpatient facilities described in Section 148.25(b)(2)(D).
- 1) Effective July 1, 1990, encounter rate hospitals are defined as these hospitals described in Section 148.25(b)(2)(B).
- 2) Effective July 1, 1991, encounter rate hospitals are defined as:
 - A) these hospitals described in Section 148.25(b)(2)(A) or
 - B) these hospitals described in Section 148.25(b)(2)(B) or
 - C) these county-operated outpatient facilities described in Section 148.25(b)(2)(D).
- 3) Effective September 1, 1991, encounter rate hospitals are defined as:
 - A) these hospitals described in Section 148.25(b)(2)(A) or
 - B) these hospitals described in Section 148.25(b)(2)(B) or

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Section 148.140(c)(3) (continued)

- C) these hospitals described in Section 148.25(b)(2)(C) or
- D) these county-operated outpatient facilities described in Section 148.25(b)(2)(D).
- 4) For encounter rate hospitals with the exception of these county-operated outpatient facilities described in Section 148.25(b)(2)(D), a Hospital Ambulatory Care list defines these technical procedures that require the use of the hospital outpatient setting, its technical staff and/or equipment. This list is updated periodically. The procedures are grouped according to type and complexity, each with a separate rate structure as follows:
 - A) High-level technology surgeries are reimbursed at the lesser of charges or the hospital's alternate reimbursement rate, as defined in Section 148.270(a), equivalent to the rate of a one-day inpatient stay.
 - B) Certain non-surgical, very high-level technology services recognized and approved by the Department as safe outpatient procedures will be reimbursed in a category separate from other specialized cardiac and diagnostic procedures and will be reimbursed at the lesser of charges or one of two separate rate maximums depending upon whether the hospital is classified as:
 - i) a children's hospital, as defined in 89-III-Adm-Code 149.50(e)(3) or a major teaching hospital, as defined in Section 148.25(b) or
 - ii) with the exception of a children's hospital, as defined in 89-III-Adm-Code 149.50(e)(3), a hospital defined in Section 148.25(e) through (f).
 - C) Other surgically specialized cardiac and diagnostic procedures will be reimbursed at the lesser of charges or one of two separate rate maximums depending upon whether the hospital is classified as:
 - i) a children's hospital, as defined in 89-III-Adm-Code 149.50(e)(3) or a major teaching hospital, as defined in Section 148.25(d) or
 - ii) with the exception of a children's hospital, as defined in 89-III-Adm-Code 149.50(e)(3), a hospital

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Section 148.140(c)(4)(C)(ii) (continued)

Section 148.140(c)(10) (continued)

defined in Section 148.25(e) through (f).

eligibility and scope of services available to those clients which pertain to the service billed are applicable to encounter rate hospitals in the same manner as to hospitals reimbursed under the Ambulatory Care Program and to non-hospital and hospital providers who bill and receive reimbursement on a fee-for-service basis.

D) Specialized treatment procedures, observation services, high-risk, and emergency room services will be reimbursed at the lesser of charges or a set rate maximum or one of two separate rate maximums depending upon whether the hospital is classified as:

i) a children's hospital as defined in 89 Ill. Adm. Code 149.50(e)(3) or a major teaching hospital as defined in Section 148.25(d) or

11) Inpatient restricted procedures as provided in subsection (a)(4) shall apply to encounter rate hospitals.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

ii) with the exception of a children's hospital as defined in 89 Ill. Adm. Code 149.50(e)(3), a hospital defined in Section 148.25(e) through (f) and

Section 148.150 Uncompensated Care Payment Adjustments

iii) whether the service is provided in the outpatient, general, clinic, psychiatric, or rehabilitation clinic department.

a) The Department shall make uncompensated care payments to qualified hospitals that are reimbursed under Sections 148.170, 148.250 through 148.290 or 89 Ill. Adm. Code 149. The Department shall adjust each of these uncompensated care payments to ensure that aggregate payments do not exceed the amount that can reasonably be estimated would have been paid under Medicare payment principles, in compliance with 42 CFR 447.272, Application of Upper Payment Limits.

5) For an encounter rate hospital described in Section 148.25(b)(2)(B), all outpatient and hospital-based clinic services not described in subsection (b)(4) above are reimbursed at a set rate maximum.

b) For the period August 1, 1991 through September 30, 1992, July 31, 1992, the hospital's uncompensated care payment shall be calculated and paid in accordance with the statutes and administrative rules governing the time period when the services were rendered.

6) For county-operated outpatient facilities described in Section 148.25(b)(2)(D), all outpatient services are reimbursed at a set rate maximum.

c) As a condition of eligibility for an uncompensated care payment adjustment during the August 1, 1991, uncompensated care rate year, each hospital shall submit, on or before October 1 of the uncompensated care rate year January 15, 1992, the following information separated by inpatient and outpatient and (including hospital-based clinic services) information to the Department for the period August 1, 1990 through July 31, 1991:

7) Effective October 1, 1992, and in subsequent years, effective the first day of July of each year, reimbursement rates described in subsections (4), (5) and (6) above shall be adjusted by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost report.

8) Encounter rate hospitals are required to submit outpatient cost reports to the Department within 90 days after the close of the hospital's fiscal year. The Department shall reconcile encounter rate hospital reimbursement rates to the amount described in subsection (7) above.

1) The dollar amount of uncompensated care charges rendered in the period described above.

2) The dollar amount of charges rendered during this period reimbursed by the Department under General Assistance (Article VI of the Public Aid Code) or Aid to the Medically Indigent (Article VII of the Public Aid Code).

9) Services are available to all clients in geographic areas in which an encounter rate hospital is located.

3) The dollar amount of Medicaid charges rendered in the period described above.

10) All specific client coverage policies relating to client

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Section 148.150(c) (continued)

- 4) The dollar amount of total charges for care rendered in the period described above.
- a) For the period August 1, 1993, through September 30, 1993, the hospital's uncompensated care payment shall be calculated in accordance with Section 148.20(b). This payment is contingent upon the Department's receipt of the data described in subsection (e) above in accordance with the time limitation described in subsection (e) above.
- a) Effective on or after October 1, 1992, as a condition of eligibility for an uncompensated care payment adjustment for the uncompensated care rate year, each hospital shall annually submit, on or before October 1 of the uncompensated care rate year (or on or before October 21, 1992, for the October 1992 uncompensated care rate year), the following information separated by inpatient and outpatient and (including hospital-based clinic services) information to the Department:
 - 1) The dollar amount of uncompensated care charges rendered in the previous uncompensated care base year.
 - 2) The dollar amount of charges rendered in the previous uncompensated care base year that are reimbursable by the Department for those program participants covered under the Family and Children Assistance Program, formerly known as the General Assistance Program (Article VI of the Public Aid Code).
 - 3) The dollar amount of Medicaid charges rendered in the previous uncompensated care base year.
 - 4) The dollar amount of total charges for care rendered in the previous uncompensated care base year.
- e) Effective on or after October 1, 1992, as a condition of eligibility for an uncompensated care payment adjustment for the uncompensated care rate year, hospitals that did not comply with the data requirements described in subsection (e) above shall submit, on or before October 21, 1992, the data required under subsection (e) above in addition to the data required under subsection (e) above. Effective on or after October 1, 1992, as a condition of eligibility for an uncompensated care payment adjustment for the uncompensated care rate year, hospitals that did not comply with the data requirement described in subsection (e) above for the previous uncompensated care rate year shall submit, on or before October 1 of the uncompensated care rate year, the data required under subsection

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- (e) above for the previous uncompensated care rate year in addition to the data required under subsection (e) above. Condition of Eligibility - Data Requirements
- 1) Effective with the October 1, 1992, uncompensated care rate year, as a condition of eligibility for an uncompensated care payment adjustment for the uncompensated care rate year, hospitals that did not comply with the data requirements described in subsection (c) above shall submit, on or before October 21, 1992, the data required under subsection (c) above in addition to the data required under subsection (d) above.
- 2) With respect to the October 1, 1993, uncompensated care rate year:
 - A) As a condition of eligibility for the total uncompensated care payment adjustment for the October 1, 1993, uncompensated care rate year, hospitals that did not comply with the data requirement described in subsection (c) above for the initial uncompensated care base year shall be required to submit, on or before October 1, 1993, the data described in subsection (c) above in addition to the data required under subsection (d) above.
 - B) Subject to the provision of subsection (e)(2)(C) below, a hospital that did not comply with the requirements of subsection (e)(2)(A) above on or before October 1, 1993, shall not be eligible for uncompensated care payment adjustments for the October 1, 1993, uncompensated care rate year.
 - C) Notwithstanding the provisions of subsection (e)(2)(B) above, a hospital that has failed to comply with the requirements of subsection (e)(2)(A) above on or before October 1, 1993, but does comply with such requirements on or before November 5, 1993, shall be ineligible for the first quarterly uncompensated care payment adjustment, but shall be eligible for the final three quarterly uncompensated care payment adjustments, subject to the requirements of subsection (j) of this Section.
- 3) Effective on or after October 1, 1994, as a condition of eligibility for an uncompensated care payment adjustment for the uncompensated care rate year, hospitals that did not comply with the data requirement described in subsection (c) above for the initial uncompensated care base year shall be required to

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submit, by the first day of October of the uncompensated care rate year, the data described in subsection (c) above in addition to the data required under subsection (d) above. A hospital that does not comply with these data requirements by the first day of October of the uncompensated care rate year shall be ineligible for uncompensated care payment adjustments in the uncompensated care rate year.

l)g) The data submitted under subsections (c), (d) and (e) and (f) above shall be contain a statement for the uncompensated care rate year signed by the chief financial officer or chief executive officer certifying to the accuracy of the data submitted.

l)h) Effective with the on or after October 1, 1992, uncompensated care rate year, all hospitals that are reimbursed under Sections 148.170, 148.250 through 148.300, or 89 Ill. Adm. Code 149 that are required to submit cost reports in accordance with Section 148.210(a) shall be eligible for an uncompensated care payment adjustment for the uncompensated care rate year subject to the reporting requirements of subsections (c), (d) and (e) and (f) above, and the provisions of subsection (j) subsection (i) below. The uncompensated care payment for the uncompensated care rate year shall be calculated by multiplying the number of Medicaid days, excluding days for normal newborns, provided by the hospital in the uncompensated care base fiscal year which were subsequently adjudicated by the Department through the last day of June preceding the uncompensated care rate year and contained within the Department's paid claims data base by \$52.65.

h) Effective on or after October 1, 1993, all hospitals that are reimbursed under Sections 148.250 through 148.300, or 89 Ill. Adm. Code 149 that are required to submit cost reports in accordance with Section 148.210(a) shall be eligible for an uncompensated care payment adjustment for the uncompensated care rate year subject to the reporting requirements of subsections (c), (d) and (e) above, and the provisions of subsection (j) below. The uncompensated care payment for the uncompensated care rate year shall be calculated by multiplying the number of Medicaid days, excluding days for normal newborns, provided by the hospital in the uncompensated care base fiscal year which were subsequently adjudicated by the Department through the last day of June preceding the uncompensated care rate year and contained within the Department's paid claims data base by \$52.65.

i) In addition to the amount calculated in subsections (g) and (h) above, for the period July 1, 1993, through June 30, 1994, each

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hospital shall receive an additional uncompensated care payment adjustment. This additional uncompensated care payment adjustment shall be calculated by dividing \$16.5 million by the number of Medicaid days, excluding days for normal newborns, provided by all hospitals in the uncompensated care base fiscal year which were subsequently adjudicated by the Department through the last day of June preceding the uncompensated care rate year and contained within the Department's paid claims data base.

j) Effective on or after October 1, 1992, a hospital will not be eligible for an uncompensated care payment adjustment under this Section for the uncompensated care rate year if the data supplied under subsections (c), (d) and (e) and (f) above indicate a significant decrease in the level of uncompensated care utilization rate. This determination will be made by comparing the level of uncompensated care provided in the immediately previous uncompensated care base year to the level of uncompensated care provided in the initial base year of August 1, 1990, through July 31, 1991. For purposes of this determination, uncompensated care in the base year of August 1, 1990, through July 31, 1991, and in subsequent uncompensated care base years shall, in addition to its usual definition, include charges for services reimbursable by the Department under the Family and Children Assistance Program, formerly known as General Assistance (Article VI), and Aid to the Medically Indigent (formerly Article VII). For example, eligibility for a payment adjustment for the uncompensated care rate year beginning October 1, 1992, shall be subject to a determination that there is not a significant decrease in the level of uncompensated care utilization rate provided from August 1991 through July 1992 as compared to the level of uncompensated care provided from August 1990 through July 1991. Factors which the Department may consider in determining whether a significant decrease in uncompensated care has occurred may include, but not be limited to, a change in socioeconomic characteristics of the community.

k) Reimbursement for uncompensated care payment adjustments shall be made on a quarterly basis, payable to the hospital in the quarter following each quarter for which the hospital is entitled to an uncompensated care payment adjustment.

l) All hospitals eligible for an uncompensated care payment adjustment shall be deemed to have met the requirements of Section 5-17 of the Public Aid Code that hospitals provide equal access to available services to low-income persons who are eligible for assistance under Articles V, VI and VII of the Public Aid Code. Nothing in this subsection shall be construed to imply that a hospital that is

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Section 148.150(1) (continued)

.ineligible for an uncompensated care payment adjustment has not met the requirements of Section 5-17 of the Public Aid Code.

- m) Inpatient Payment Adjustments Based Upon Uncompensated Care Payment Adjustment Reviews. Appeals based upon a hospital's ineligibility for the uncompensated care payment adjustments described in this Section, or their payment adjustment amounts, in accordance with Section 148.310, which result in a change in a hospital's eligibility for uncompensated care payment adjustments or a change in a hospital's uncompensated care payment adjustment amounts, shall not affect the uncompensated care payment adjustments of any other hospital or the payment adjustment amount of any other hospital that has received notification from the Department of their eligibility for uncompensated care payment adjustments based on the requirements of this Section.

n) Definitions

- 1) "Medicaid charges" means hospital charges for inpatient, outpatient and hospital-based clinic services provided to recipients of medical assistance under Title XIX of the Social Security Act.
- 2) "Medicaid Days" means hospital days reimbursed by the Department for recipients of medical assistance under Title XIX of the Social Security Act.
- 3) "Total charges" means the total amount of a hospital's charges for inpatient, outpatient and hospital-based clinic services it has provided.
- 4) "Uncompensated care base fiscal year" means, for example, State Fiscal Year 1991, for the October 1, 1992, uncompensated care rate year, State Fiscal Year 1992, for the October 1, 1993, uncompensated care rate year, etc.
- 5) "Uncompensated care base year" means August 1 through July 31 of each year, beginning with the initial August 1, 1990, through July 31, 1991, base year.
- 6) "Uncompensated care charges" for a hospital means:
 - A) the hospital's charges for inpatient, outpatient and hospital-based clinic services for which the hospital was not reimbursed by either the patient or a third party (including the Department);

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B) less:

- i) the amount of the hospital's bad debt recoveries for inpatient, outpatient and hospital-based clinic services; and
- ii) the hospital's charges attributable to inpatient, outpatient and hospital-based clinic services that if provided without charge or at reduced charges under its obligation under the federal Hill-Burton Act (42 U.S.C. 291 et seq.).

7) "Uncompensated care rate year" means October 1 through September 30 of each year, beginning with the October 1, 1992 rate year.

8) "Uncompensated care utilization rate" means a fraction, the numerator of which is the hospital's uncompensated care charges provided in a given twelve month period, and the denominator of which is the hospital's total charges in that same period. In this paragraph, the term "uncompensated care charges" shall include, in addition to its usual definition, charges for services reimbursable by the Department under the Family and Children Assistance Program, formerly known as General Assistance (Article VI), and Aid to the Medically Indigent (formerly Article VII).

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 148.160 Payment Methodology for County-Owned Hospitals in an Illinois County with a Population of Over 3 Million

a) Reimbursement Methodology

In accordance with 89 Ill. Adm. Code 149.50 (c)(8), county-owned hospitals in an Illinois county with a population greater than three million are excluded from the DRG PPS and are reimbursed in accordance with this section.

b) Base Year Costs

- 1) The hospitals' Each-hospital's base year operating costs shall be the Medicaid-cost-per-diem contained in the hospitals' hospital's audited cost reports (see 42 CFR 447.260 and 447.265 (1982)) for hospitals fiscal years ending between 20 19 and 31 30 months prior to the fiscal year for which rates are being set

Section 148.160(b)(1) (continued)

(five-year calendar year-1980 for fiscal year-1992 rates, calendar year-1990 for fiscal year-1993 rates, etc.), in the event that an audited cost report is not available at the time rates are calculated, the unaudited report for the applicable period shall be used for the calculation of interim rates. Upon completion of the audit, the rates shall be recalculated. Payments made under the interim rate shall be reconciled.

2) The hospitals' Each hospital's base year capital related costs shall be derived from the same audited cost reports report used for operating costs in subsection (b)(1) above.

3) The hospitals' Each hospital's base year direct medical education costs shall be derived from the same audited cost reports report used for operating costs in subsection (b)(1) above.

4) Each hospital's The base year cost per diem costs shall be the sum of the hospital's operating cost per diem costs, capital related cost per diem costs and medical education cost per diem costs defined in subsections (b)(1) through (b)(3).

5) For new hospitals, for which a base year cost report is not on file, the Department will be reimbursed the per diem rate calculated in subsection (b)(4) above and inflated in subsection (d)(1) below. Use a more recently filed cost report, or if no cost report is on file, the hospital's estimate of costs, adjusted as necessary according to experience with hospitals of similar size, location and service intensity. The Department will recalculate any reimbursement rate based on a rate estimated as seen as a cost report becomes available. The recalculated rate will be effective for the entire fiscal year and the Department will retroactively adjust payments if reported costs are not consistent with the estimate on which the payments are based.

c) Restructuring Adjustments

Adjustments to the base year cost per diem, as described in subsection (b)(4) above. Base year costs will be made to reflect restructuring since filing the base year cost reports report. The restructuring must have been mandated to meet state, federal or local health and safety standards. The allowable Medicare/Medicaid costs (see 42 CFR Part 405, Subpart D, 1982) must be incurred as a result of mandated restructuring and identified from the most recent audited cost reports report available before or during the rate year. The

Section 148.160(c) (continued)

restructuring costs must be significant, i.e., on a per unit basis; they must constitute one percent or more of the total allowable Medicare/Medicaid unit costs for the same time period. The Department will use the most recent available audited cost reports report to determine restructuring costs. If an audited cost reports report becomes available during the rate year, the reimbursement rate will be recalculated at that time to reflect restructuring cost adjustments. For audited reports received at the Office of Health Finance, Illinois Department of Public Aid, between the first and fifteenth of the month, the effective date of the recalculated rate will be the first day of the following month. For audited reports received at the Finance Section between the sixteenth and last day of the month, the effective date will be the first day of the second month following the month the reports are received. Allowable restructuring costs are adjusted to account for inflation from the midpoint of the restructuring cost reporting year to the midpoint of the base year according to the index and methodology of Data Resources, Inc. (DRI), national hospital market basket price proxies and added to the base year cost per diem, as described in subsection (b)(4), which is subject to the inflation adjustment described in subsection (d) below base year costs.

d) Inflation Adjustment For Base Year Cost Report Inflator

1) The base year cost per diem, as defined in subsection (b)(4) above, shall be inflated from the midpoint of the hospitals' base year to the midpoint of the time period for which rates are being set (rate period) according to the historical rate of annual cost increases. The historical rate of annual cost increases shall be calculated by dividing the operating cost per diem as defined in subsection (b)(1) above by the previous year's operating cost per diem.

2) Effective October 1, 1992, and in subsequent years, effective the first day of July of each year, base year costs, including any adjustments for mandated restructuring, shall be adjusted by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost report; however, in no instance shall the adjusted rate effective October 1, 1992, and thereafter, be less than the rate in effect on June 1, 1992. The final reimbursement rate shall be no less than the reimbursement rate in effect on June 1, 1992; except that this minimum shall be adjusted each July 1 thereafter by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost reports.

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e) Review Procedure

The review procedure shall be in accordance with Section 148.310.

f) Applicable Adjustments for DSH Hospitals

- 1) The criteria and methodology for making applicable adjustments to DSH hospitals which are exempt from the DRG PPS as described in subsection (a) above, shall be in accordance with Section 148.120.
- 2) In addition to the DSH payment adjustments described in Section 148.120, hospitals reimbursed under this Section shall have receive supplemental DSH payments. Effective with admissions on or after October 1, 1993, supplemental DSH payments for hospitals reimbursed under this Section shall be calculated by multiplying the sum of the base year cost per diem, as described in subsection (b)(4) above, as adjusted for restructuring, as described in subsection (c) above, and as adjusted for inflation, as described in subsection (d) above, and hospital's base-year costs plus the calculated disproportionate share per diem payment adjustment adjustments per diem from as described in Section 148.120, by the hospitals' hospital's percentage of inpatient-days charges which are not reimbursed by a third party payer for the period of August 1, 1991, through July 31, 1992. Effective October 1, 1992, and in subsequent years, effective the first day of July of each year, the supplemental DSH payments calculated under this subsection shall be no less than the supplemental DSH rates in effect on June 1, 1992, except that this minimum shall be adjusted as of July 1, 1992, and on the first day of July of each year thereafter, by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost reports; however, in no instance shall the supplemental DSH payments calculated effective October 1, 1992, and thereafter, be less than the supplemental DSH payments in effect on June 1, 1992. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid cost by the total allowable Medicaid days. The supplemental DSH payment adjustment shall be paid on a per diem basis and shall be applied to each covered day of care provided.

g) Outlier Adjustments

Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for

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Section 148.160(g) (continued)

certain individuals shall be made in accordance with Section 148.130.

h) Trauma Center Adjustments. Trauma center adjustments shall be made in accordance with Section 148.290(c).

i) Reductions to Total Payments

- 1) Copayments. Copayments are assessed under all medical programs administered by the Department except the Family and Children Assistance Program, formerly known as the General Assistance Program, and shall be assessed in accordance with Section 148.190.

- 2) Third Party Payments. The requirements of Section 148.290(j)(2) 148.290(e)(2) shall apply.

j) Prepayment and Utilization Review

Prepayment and utilization review requirements shall be in accordance with Section 148.240.

k) Cost Reporting Requirements

Cost reporting requirements shall be in accordance with Section 148.210.

l) Rate Period

The rate period for hospitals reimbursed under this Section shall be the 12 month period beginning on October 1 of the year and ending September 30 of the following year.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 148.170 Payment Methodology for State-Owned Hospitals Organized Under the University of Illinois Hospital Act in an Illinois County with a Population of Over 3 Million

- a) In accordance with 89 Ill. Adm. Code 149.50(c)(8), a hospital organized under the University of Illinois Hospital Act shall be state-owned hospitals in an Illinois county with a population greater than three million are excluded from the DRG PPS and shall be are reimbursed in accordance with this Section section.

b) Base Year Costs

Section 148.170 (continued)

- d) Inflation Adjustment For Base Year Cost Report Inflator
- Base year costs, including any adjustments for mandated restructuring, will be updated from the midpoint of each hospital's base year to the midpoint of the fiscal year rate-period for which rates are being set according to the hospital's historical rate of annual cost increases index-and methodology-of-Data-Resources-Inc-(DRI)-national-market-basket-price-premies.

- e) Review Procedure

The review procedure shall be in accordance with Section 148.310.

- f) Applicable adjustments for DSH Hospitals and Uncompensated-Care

1) The criteria and methodology for making applicable adjustments to DSH hospitals which are exempt from the DRG FPS as described in subsection (a) above, shall be in accordance with Section 148.120. The criteria-and methodology-for-making-applicable adjustments-for-uncompensated-care-shall-be-in-accordance-with Section-148.150.

- 2) Effective October 1, 1993, in addition to the DSH payment adjustments described in Section 148.120, hospitals reimbursed under this Section shall have supplemental DSH payments. Effective with admissions on or after October 1, 1993, supplemental DSH payments for hospitals reimbursed under this Section shall be calculated by multiplying the sum of the hospital's base year costs, as described in subsection (b) above, as adjusted for restructuring, as described in subsection (c) above, and as adjusted for inflation, as described in subsection (d) above, and the calculated disproportionate share per diem payment adjustment as described in Section 148.120, by the hospital's percentage of charges which are not reimbursed by a third party payer for the period of August 1, 1991, through July 31, 1992. The resulting product shall be multiplied by 2.25 and this amount shall be the supplemental DSH payment adjustment which shall be paid on a per diem basis and shall be applied to each covered day of care provided.

- g) Outlier Adjustments

Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for certain individuals shall be made in accordance with Section 148.130.

Section 148.170(b) (continued)

- 1) Each hospital's base year cost per diem shall be derived from an audited cost report reports (see 42 CFR 447.260 and 447.265 (1982)) for hospitals' fiscal year 1990 years-ending-between-19 and-30-months-prior-to-the-fiscal-year-for-which-rates-are-being set-(i.e., Calendar-Year-1980-for-fiscal-Year-1992-rates, Calendar-Year-1990-for-fiscal-Year-1993-rates-etc.)-will-be used-to-define-base-year-costs.

- 2) For new hospitals for which a base year cost report is not on file, the Department will use a more recent filed cost report or, if no cost report is on file, the hospital's estimate of costs, adjusted as necessary according to experience with hospitals of similar size, location and service intensity. The Department will recalculate any reimbursement rate based on a rate estimated as soon as a cost report becomes available. The recalculated rate will be effective for the entire fiscal year and the Department will retroactively adjust payments if reported costs are not consistent with the estimate on which the payments are based.

- c) Restructuring Adjustment

Adjustments to base year costs will be made to reflect restructuring since filing the base year cost report. The restructuring must have been mandated to meet state, federal or local health and safety standards. The allowable Medicare/Medicaid costs (see 42 CFR Part 405, Subpart D, 1982) must be incurred as a result of mandated restructuring and identified from the most recent audited cost report available before or during the rate year. The restructuring costs must be significant, i.e., on a per unit basis; they must constitute one percent or more of the total allowable Medicare/Medicaid unit costs for the same time period. The Department will use the most recent available audited cost report to determine restructuring costs. If an audited cost report becomes available during the rate year, the reimbursement rate will be recalculated at that time to reflect restructuring cost adjustments. For audited reports received at the Office of Health Finance, Illinois Department of Public Aid, between the first and fifteenth of the month, the effective date of the recalculated rate will be the first day of the following month. For audited reports received at the Finance Section between the sixteenth and last day of the month, the effective date will be the first day of the second month following the month the report is received. Allowable restructuring costs are adjusted to account for inflation from the midpoint of the restructuring cost reporting year to the midpoint of the base year according to the index and methodology of Data Resources, Inc. (DRI), national hospital market basket price proxies and added to the base year costs.

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Section 148.170 (continued)

h) Reductions to Total Payments

- 1) Copayments. Copayments are assessed under all medical programs administered by the Department except the Children and Family Assistance Program, formerly known as the General Assistance Program, and shall be assessed in accordance with Section 148.190.
- 2) Third Party Payments. The requirements of Section 148.200(j)(2) 148-200(e)(4) shall apply.

i) Prepayment and Utilization Review

Prepayment and utilization review requirements shall be in accordance with Section 148.240.

j) Cost Reporting Requirements

Cost reporting requirements shall be in accordance with Section 148.210.

k) Rate Period

The rate period for hospitals reimbursed under this Section shall be the 12 month period beginning on October 1 of the year and ending September 30 of the following year. In the event that an audited cost report is not available at the time rates are calculated, the unaudited report for the applicable period shall be used for the calculation of interim rates. Upon completion of the audit, the rates shall be recalculated. Payments made under the interim rate shall be rescinded.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 148.180 Payment for Pre-operative Days, Patient Specific Orders, and Services Which Can Be Performed in an Outpatient Setting

- a) Pre-Operative Days. For hospitals and distinct part units reimbursed on a per diem basis under Sections 148.160, 148.170 or 148.250 through 148.300, payment for pre-operative days shall be limited to the day immediately preceding surgery unless the attending physician has documented the medical necessity of an additional day or days. The documentation must be kept in the patient's medical record and must consist of a written notation made by the physician which documents that more than one pre-operative day is medically necessary.

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Section 148.180 (continued)

b) Inpatient Procedures Requiring Justification

- 1) A list of restricted inpatient procedures has been established. These restricted inpatient procedures will only be reimbursed when performed outside the inpatient setting or when the hospital supplies justification for an inpatient admission that meets Departmental established criteria. These criteria include, but are not limited to: in accordance with Section 148.140(a)(4), payment for inpatient hospital services will not be made for procedures which have been identified as procedures which may be performed safely in an outpatient setting (i.e., without an admission to the hospital for an overnight stay) unless documentation in the patient's medical record indicates that:
 - A) Presence of medical conditions which make prolonged post-operative observations by a nurse or skilled medical personnel a necessity (e.g., heart disease, severe diabetes);
 - B) The patient is in the hospital as an inpatient for a medically necessary condition unrelated to the surgical procedure;
 - C) An unrelated procedure is being done simultaneously which itself requires surgical hospitalization; the patient is in the hospital as an inpatient for an unrelated procedure to be performed on an inpatient basis simultaneously;
 - D) The practitioner has documented the medical necessity of performing the patient's surgery in an inpatient setting;
 - E) The patient is unable to comprehend and/or follow the necessary instruction both prior to and following the procedure due to mental and/or physical impairment, and this would result in inadequate treatment and place the patient at risk;
 - F) Emergency admission or recent onset of severe symptoms would prohibit safely performing the procedure on an outpatient basis (e.g., bleeding, severe pain, nausea, vomiting); and
 - G) Admission occurs subsequent to the performance of the procedure on an outpatient basis due to conditions such as:

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Section 148.180(b)(1)(G) (continued)

Section 148.180(c) (continued)

- i) Instability of vital signs;
- ii) Respiratory distress greater than existed pre-operatively;
- iii) Post-operative pain not relieved by oral medication;
- iv) Uncontrolled bleeding;
- v) Lack of state of consciousness appropriate to age and development;
- vi) Presence of persistent nausea or vomiting; and
- vii) Inability to ambulate consistent with age, previous mobility status and/or procedure.

- 2) Upon completion of the service or test, a fully documented description of results with findings, or the administration of medication, must be maintained in the patient medical records. Radiological services must have the actual x-rays and the interpretation report; laboratory/pathological tests must have the specific findings for each test; and drugs and pharmaceutical supplies must indicate strength, dosages and durations.
- 3) Charges for any and all such services or tests cannot exceed those charged to the general public. The failure to maintain and provide records as described in this Section shall result in the disallowance of the applicable charges upon audit.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

- 2) The list of procedures identified as restricted inpatient procedures which may be safely performed outside the inpatient setting and do not require that an inpatient admission are would be reevaluated periodically annually.
- 3) Additions to and deletions from the list of designated restricted inpatient procedures will be made following notice to and consultations with the Department's professional advisory committees, State Medicaid Advisory Committee, representatives selected by the hospitals, other third party payors, the Illinois Hospital Association, and other interested groups or individuals.

Section 148.200 Alternate Reimbursement Systems

- a) Section 148.210 discusses cost reporting requirements for all hospitals participating in the Medicaid Program.
- b) Section 148.220 describes the payment methodology for hospital inpatient services to recipients for admissions occurring prior to September 1, 1991.
- c) The payments described in Sections 148.250 through 148.300 shall be effective for admissions on and after October 1, 1992. September 1, 1991, subject to the provisions of Section 148.20(b).

c) Ancillary Services and Tests

- d) The payments described in Section 148.82 148.80 shall be effective for admissions on and after September 1, 1991, with the exception of provisions that relate to pancreas or kidney-pancreas transplants. Provisions relating to pancreas or kidney-pancreas transplants shall be effective for admissions on and after July 1, 1992.
- e) Sections 148.250 through 148.300 describe the payment methodologies for hospital inpatient services to recipients of Medical Assistance provided by a hospital not reimbursed under the DRG Prospective Payment System (PPS) described in 89 Ill. Adm. Code 149 or the reimbursement methodologies described in Sections 148.82 148.80, 148.160 and 148.170.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

- 1) Ancillary services and routine tests (those services other than routine room and board and nursing which are required because of the patient's medical condition, including lab tests and x-rays) shall not be covered unless there is a patient specific written order for the test from the attending or operating physician responsible for the care and treatment of the patient. The attending or operating physician responsible for the care and treatment of the patient is required to sign all applicable sections for each test ordered in the appropriate place in the medical record. The order must be legible and explain completely all services or tests to be performed. Standing orders are not acceptable.

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Section 148.210 Filing Cost Reports

- a) All hospitals in Illinois, those hospitals in contiguous states providing 100 or more inpatient days of care to Illinois program participants, and all hospitals located in states contiguous to Illinois that elect to be reimbursed under the methodology described in 89 Ill. Adm. Code 149 (the DRG Prospective Payment System), shall be required to file Medicaid cost reports within 90 days of the close of that provider's fiscal year.
- b) The Department may grant a 30-day extension of the due date for good cause.
- c) The assessment or license fees described in 89 Ill. Adm. Code Sections 140.80, 140.82, 140.84, 140.94 and 140.95, may not be reported as allowable Medicaid costs on the Medicaid cost report.
- d) For a hospital that is electing to participate in the Illinois Medicaid Program and has not filed a Medicaid cost report before, the hospital must submit the two most recently audited Medicare cost reports at the time of enrollment.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 148.230 Admissions Occurring on or after September 1, 1991

Reimbursement to hospitals not reimbursed under the DRG PPS (see 89 Ill. Adm. Code 149) or the reimbursement methodologies established at Sections 148.82, 148-89, 148.160 and 148.170 for inpatient admissions occurring on or after September 1, 1991, shall be calculated in accordance with Sections 148.250 through 148.300, subject to the provisions of Section 148.20(b).

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 148.240 Utilization Review and Furnishing of Inpatient Hospital Services Directly or Under Arrangements

a) Utilization Review

The Department, or its designee, may conduct preadmission, concurrent, prepayment, and postpayment reviews of:

- 1) The quality and nature of the utilization of health services;
- 2) The medical necessity, reasonableness and appropriateness of

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Section 148.240(a)(2) (continued)

- inpatient hospital care for which additional payment is sought under outlier provisions;
- 3) The validity of the hospital's diagnostic and procedural information;
 - 4) The completeness, adequacy and quality of the services furnished in the hospital; or
 - 5) Other medical or other practices with respect to program participants or billing for services furnished to program participants.
- b) Medical Review Notification

Hospitals shall be notified at least thirty-(30) days in advance of any preadmission, concurrent, or prepayment review requirements imposed by the Department.

c) Prepayment Review

The Department may require hospitals to submit claims to the Department for prepayment review and approval prior to rendering payment for services provided. Such prepayment review requirements will be focused on areas where the Department has substantial reason to suspect abuse (e.g., hospital billings deviate from the norm). The review may be conducted by the Department or its designated peer review agents. Prepayment review shall be used to determine the appropriateness and medical necessity of the inpatient stay. Payment shall not be made unless the medical necessity of the inpatient stay can be documented. The Department shall notify the hospital by letter or Department Informational Notice of the designated services which shall be subject to prepayment review. The prepayment review requirement shall commence thirty-(30) days after the Department has given notice to the hospital of the designated services which shall be reviewed.

d) Postpayment Review

Postpayment review shall be conducted on a random sample of hospital stays following reimbursement to the hospital for the care provided. The Department may also conduct postpayment review on specific types of care.

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Section 148.240 (continued)

e) Hospital Utilization Control. Hospitals and distinct part units that participate in Medicare (Title XVIII) must use the same utilization review standards and procedures and review committee for Medicaid as they use for Medicare. Hospitals and distinct part units that do not participate in Medicare (Title XVIII) must meet the utilization review plan requirements in 42 CFR, Ch. IV, Part 456, Subparts C, D, or E (October 1, 1991). Utilization control requirements for inpatient psychiatric hospital care in a psychiatric hospital, as defined in 89 Ill. Adm. Code 149.50(c)(1) shall be in accordance with federal regulations at 42 CFR, CH IV, Part 456, Subpart G (October 1, 1991).

f) Denial of Payment as a Result of Admissions, Length of Stay, Transfers and Quality Review

1) If the Department determines that a hospital has misrepresented admissions, length of stay, discharges, or billing information, or has taken an action that results in the unnecessary admission or inappropriate discharge of a program participant, unnecessary multiple admissions of a program participant, unnecessary transfer of a program participant, or other inappropriate medical or other practices with respect to program participants or billing for services furnished to program participants, the Department may, as appropriate:

- A) Deny payment (in whole or in part) with respect to inpatient hospital services provided with respect to such an unnecessary admission, inappropriate length of stay or discharge, subsequent readmission or transfer of an individual.
- B) Require the hospital to take action necessary to prevent or correct the inappropriate practice.
- C) Perform prepayment review in accordance with Section 148.240(c) 148.240(b).

2) When payment with respect to the discharge of an individual patient is denied by the Department or its designee, under subsection (f)(1)(A), a reconsideration will be provided within 30 days upon the request of a practitioner or provider if such request is the result of the designee's own medical necessity or appropriateness of care denial determination and is received within 60 days of the Advisory Notice. The date of the Advisory Notice is counted as day one.

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Section 148.240(f) (continued)

3) A determination under subsection (f)(1) above, if it is related to a pattern of inappropriate admissions, length of stay and billing practices that has the effect of circumventing the prospective payment system, may result in:

- A) withholding Medicaid payment (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or
- B) termination of the hospital's Provider Agreement.

g) Furnishing of Inpatient Hospital Services Directly or Under Other Arrangements

1) The applicable payments made under Sections 148.82 148.89, 148.120, 148.130, 148.150, 148.160, 148.170 and 148.250 through 148.300 are payment in full for all inpatient hospital services other than for the services of nonhospital-based physicians to individual program participants and the services of certain hospital-based physicians as described in subsections (g)(1)(B)(i) through (g)(1)(B)(v) below.

A) Hospital-based physicians who may not bill separately on a fee-for-service basis:

- i) A physician whose salary is included in the hospital's cost report for direct patient care may not bill separately on a fee-for-service basis.
- ii) A teaching physician who provides direct patient care may not bill separately on a fee-for-service basis if the salary paid to the teaching physician by the hospital or other institution includes a component for treatment services.

B) Hospital-based physicians who may bill separately on a fee-for-service basis:

- i) A physician whose salary is not included in the hospital's cost report for direct patient care may bill separately on a fee-for-service basis.
- ii) A teaching physician who provides direct patient care may bill separately on a fee-for-service basis if the salary paid to the teaching physician by the hospital or other institution does not include a component for treatment services.

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Section 148.240(g)(1)(B) (continued)

- iii) A resident may bill separately on a fee-for-service basis when, by the terms of his or her contract with the hospital, he or she is permitted to and does bill private patients and collect and retain the payments received for those services.
- iv) A hospital-based specialist who is salaried, with the cost of his or her services included in the hospital reimbursement costs, may bill separately on a fee-for-service basis when, by the terms of his or her contract with the hospital, he or she may charge for professional services and do, in fact, bill private patients and collect and retain the payments received.
- v) A physician holding a nonteaching administrative or staff position in a hospital or medical school may bill separately on a fee-for-service basis to the extent that he or she maintains a private practice and bills private patients and collects and retains payments made.
- 2) Charges are to be submitted on a fee-for-service basis only when the physician seeking reimbursement has been personally involved in the services being provided. In the case of surgery, it means presence in the operating room, performing or supervising the major phases of the operation, with full and immediate responsibility for all actions performed as a part of the surgical treatment.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 148.250 Determination of Alternate Payment Rates to Certain Exempt Hospitals

The exempt hospitals, defined in 89 Ill. Adm. Code 149.50(c)(1), (c)(2), (c)(4) and (c)(7), shall be reimbursed for inpatient hospital care provided to recipients by summing the following reimbursement calculations:

- a) allowable operating cost per diem;
- b) other costs (capital, and direct medical education, and CRNA costs) reimbursed on a per diem basis;
- c) applicable DSH adjustments as described in Section 148.120, uncompensated care adjustments as described in Section 148.150, and

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Section 148.250(c) (continued)

- outlier adjustments as described in Section 148.130; and
- d) applicable trauma center adjustments, as described in 89 Ill. Adm. Code 148.290(c), and rehabilitation hospital adjustments, as described in 89 Ill. Adm. Code 148.290(d), perinatal center adjustments, as described in 89 Ill. Adm. Code 148.290(e), obstetrical care adjustments, as described in 89 Ill. Adm. Code 148.290(f), targeted access payment adjustments, as described in 89 Ill. Adm. Code 148.290(g), and Medicaid high volume adjustments, as described in 89 Ill. Adm. Code 148.290(h) 148.290(f) through (d).

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 148.260 Calculation and Definitions of Inpatient Per Diem Rates

- a) Calculation for the first rate year period

1) Allowable operating cost per diem

- A) The allowable operating cost per diem for a hospital, described in Section 148.250 148.250(a), and for hospitals or hospital units, described in Section 148.270(a) and (b), shall be calculated by taking the hospital's Medicaid inpatient operating costs for the base period as defined in Section 148.25(g)(1) divided by the hospital's Medicaid inpatient days.

- B) In the event that an audited cost report is not available at the time rates are calculated, the unaudited report for the applicable period shall be used for the calculation of interim rates. Upon completion of the audit, the rates shall be recalculated. Payments made under the interim rate shall be renewed.

- B)(5) Operating cost base per diem rates for hospital inpatient care provided to Medicaid recipients beginning September 1, 1991, shall be calculated by:

- i) Calculating each individual hospital's cost per diem less capital and direct medical education costs for each of the two most recent years for which an audited Medicaid cost report exists, as described in subsection (a)(1)(A) above.

Section 148.260(a)(1)(B) (continued)

- ii) Each of the two costs per diem shall be trended forward to the midpoint of the rate period using the national hospital market basket price proxies (DRI).
- iii) These two trended operating costs per diem are then added together and divided by two to calculate the hospital's final operating cost per diem for the base period.

2) Capital Related Costs. The capital related cost per diem for a hospital, described in Section 148.250, and for hospitals or hospital units, described in Section 148.270(a) and (b) 148.270(b), shall be calculated by taking the hospital's total capital related costs for the base period as defined in Section 148.25(g)(1) divided by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national hospital market basket price proxies (DRI).

- A) These two trended capital related cost per diems are then added together and divided by two to calculate the hospital's adjusted capital related cost per diem.
- B) The adjusted capital related cost per diem, as calculated in subsection (a)(2)(A) above, shall be rank ordered for all hospitals and capped at the 80th percentile.
- C) Each hospital shall receive a per diem add-on for capital related costs which shall be equal to the amount calculated in subsection (a)(2)(A) or subsection (a)(2)(B) above, whichever is less.

3) Direct Medical Education Costs. The direct medical education cost per diem for a hospital, described in Section 148.250 148.260(a), and for hospitals or hospital units, described in Section 148.270(a) and (b), shall be calculated by taking total inpatient direct medical education costs for the base period as defined in Section 148.25(g)(1) divided by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national hospital market basket price proxies (DRI).

- A) The two trended direct medical education cost per diems are then added together and divided by two to calculate the hospital's adjusted direct medical education cost per diem.

Section 148.260(a)(3) (continued)

- B) The adjusted direct medical education cost per diem, as calculated in subsection (a)(3)(A) above, shall be rank ordered for all hospitals reporting such costs and capped at the 80th percentile.
- C) Each hospital shall receive a per diem add-on for direct medical education costs which shall be equal to the amount calculated in subsection (a)(3)(A) or subsection (a)(3)(B) above, whichever is less.

4) CRNA Costs

- A) Only hospitals that qualify for these payments under the Medicare Program as of September 1, 1992, shall be eligible for these payments.
- B) The CRNA cost per diem shall be calculated by taking the hospital's total CRNA costs for the base period as defined in Section 148.26(g)(1) divided by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national hospital market basket price proxies (DRI).
- C) Each qualifying hospital, as described in subsection (a)(4)(A) above, shall receive a per diem add-on for CRNA costs which shall be equal to the amount calculated under subsection (a)(4)(B) above.

b) Calculation of Direct Medical Education Costs for Subsequent Rate Periods

- 1) Effective with rate periods beginning on or after April 1, 1994, hospitals will be separated into two peer groups for the purpose of computing direct medical education cost per diems.
- 2) For the purpose of computing the direct medical education cost per diems, all hospitals described in Section 148.25(d) shall be defined as major teaching hospitals. All other hospitals reporting direct medical education costs shall be defined as other teaching hospitals.
- 3) Effective with rate periods beginning on or after April 1, 1994, the adjusted direct medical education cost per diem for all hospitals in each peer group shall be calculated by utilizing the direct medical education cost per diems for each hospital.

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Section 148.260(b)(3) (continued)

that were in effect on June 30, 1993, under the methodology described in subsections (a)(3) and (a)(3)(A) of this Section.

A) The adjusted direct medical education cost per diem, as described in subsection (b)(3) above, shall be rank ordered for all hospitals reporting such costs within each peer group, and capped at the 80th percentile.

C) Each hospital shall receive a per diem add-on for direct medical education costs which shall be equal to the amount calculated in subsection (b)(3) or subsection (b)(3)(A) above, whichever is less, subject to the inflation adjustment described in subsection (c) of this Section.

c) b) Calculation for Subsequent Subsequent Rate Periods

1) For the rate period described in Section 148.25(g)(2)(A) periods beginning on or after October 1, 1992, the final rate per diem shall be determined by taking the operating, capital, and direct medical education and CRNA trended rate cost per diem calculated under subsection (a) of this Section for the base period and updating those costs by the national hospital market basket price proxies (DRI) to the midpoint of the rate period described in Section 148.25(g)(2)(A).

2) For rate periods beginning on or after April 1, 1994, as described in Section 148.25(g)(2)(B), the final rate per diem shall be determined by:

A) Adding the operating and capital trended rate cost per diem calculated under subsection (a) of this Section that were in effect on June 30, 1993;

B) Adding the direct medical education trended rate cost per diem calculated under subsection (c) of this Section to the resulting sum described in subsection (c)(2)(A) above; and

C) Updating the trended rate cost per diem described in subsections (c)(2)(A) and (c)(2)(B) above:

i) In the case of a hospital described in 89 Ill. Adm. Code 149.125(b), by the national hospital market basket price proxies (DRI) to the midpoint of the rate period described in Section 148.25(g)(2)(B); and

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Section 148.260(c)(2)(C) (continued)

ii) In the case of a hospital described in 89 Ill. Adm. Code 149.50(c)(1), (c)(2), or (c)(4), or for a hospital unit described in 89 Ill. Adm. Code 149.50(d)(1) or (d)(2), to the midpoint of the current rate period described in Section 148.25(g)(2)(B) by utilizing the TEPPA price inflation factor.

d) e) Rebasing

For the rate period beginning after October 1, 1994, and every third rate period thereafter, the final rate per diem shall be calculated using:

1) The methodology set forth in subsection (a) of this Section for the calculation of operating and capital trended rate cost per diem using base period cost reports, as described in Section 148.25(g)(1); and the most recently available audited Medicare/Medicaid cost reports.

2) The methodology set forth in subsection (c) of this Section for the calculation of direct medical education trended rate cost per diem using base period cost reports, as described in Section 148.25(g)(1).

d) In the event that an audited cost report is not available at the time rates are calculated, the unaudited report for the applicable period shall be used for the calculation of interim rates. Upon completion of the audit, the rates shall be recalculated. Payments made under the interim rate shall be reconciled.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 148.270 Determination of Alternate Cost Per Diem Rates For All Hospitals; and Payment Rates for Certain Exempt Hospital Units; and Payment Rates for Certain Other Hospitals

a) Calculation of Alternate Cost Per Diem Rates for All Hospitals
For all hospitals, regardless of the hospital's reimbursement methodology, the Department shall first calculate the hospital's alternate cost per diem rate, as calculated under Section 148.260, derived from the provider's base period cost reports, as described in Section 148.25(g)(1) two most recently audited inpatient-Medicare cost reports and the latest Medicare cost reports on file with the Department.

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Section 148.270 (continued)

b) Calculation of Payment Rates for Certain Exempt Hospital Units

1) For admissions occurring within the rate period described in Section 148.25(g)(2)(A):

A) In the case of a distinct part unit, as described in 89 Ill. Adm. Code 149.50(d), the Department shall divide the hospital's Medicaid charges per diem (identified on adjudicated paid claims submitted by the provider individual hospital during the most recently completed fiscal year for which complete data are available) related to the distinct part unit by the hospital's total Medicaid charges per diem for all paid claims for from the same time period, and multiply the result by the hospital's total Medicaid alternate payment rate. For rehabilitation care, the resulting figure shall be used as the hospital's distinct part unit's payment rate. A hospital's distinct part unit's per diem shall be the lesser of the hospital's calculated per diem rate or the mean distinct part unit rate, plus three standard deviations. For psychiatric care, the lower of the resulting figure or the hospital's Medicaid alternate payment rate shall be used as the hospital's distinct part unit's payment rate. In the case of a new distinct part unit for which the Department has insufficient paid claims history data available, the Department shall utilize the average payment rate calculated under this subsection (b) for like units.

B) The resulting quotient, as calculated in subsection (b)(1)(A) above, shall be multiplied by the hospital's total operating cost per diem, as calculated in Section 148.260(a)(1)(B).

C) The capital related cost per diem, as calculated in Section 148.260(a)(2), and the direct medical education cost per diem, as calculated in Section 148.260(a)(3), are then added to the resulting product calculated in subsection (b)(1)(B) above, subject to the inflation adjustment described in Section 148.260(c)(1).

D) Subject to the provisions of subsection (b)(1)(E) and (b)(1)(F) below, the final distinct part unit payment rate shall be the lower of:

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Section 148.270(b)(1)(D) (continued)

i) The result of the calculations described in subsections (b)(1)(A) through (b)(1)(C) above; or
ii) The hospital's alternate cost per diem rate, as calculated in subsection (a) above.

E) In no case shall the hospital's final distinct part unit payment rate be greater than three standard deviations above the mean distinct part unit payment rate.

F) In the case of a new distinct part unit for which the Department has insufficient adjudicated claims history data available, the Department shall utilize the average payment rate calculated under this subsection (b)(1) for like distinct part units.

2) For admissions occurring within a rate period described in Section 148.25(g)(2)(B), the distinct part unit payment rate shall be the distinct part unit payment rate in effect on June 30, 1993, as calculated under subsection (b)(1) above, updated to the midpoint of the current rate period, using the TFRA price inflation factor.

c) In the case of a new hospital (not previously owned or operated), a hospital that has significantly changed its case-mix profile (e.g. a general acute care hospital changing its case-mix to reflect a predominance of long term care patients), or an out-of-state non cost-reporting hospital, reimbursement for inpatient services shall be as follows:

1) For general acute-care hospitals, reimbursement for inpatient services shall be at the average payment rate calculated under subsection (a) or (b) above, as applicable, for those hospitals reimbursed under 89 Ill. Adm. Code 149.

2) For psychiatric hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(1), reimbursement for inpatient psychiatric services shall be at the average rate calculated under Section 148.260 for those hospitals defined in 89 Ill. Adm. Code 149.50(c)(1).

3) For rehabilitation hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(2), reimbursement for inpatient rehabilitation services shall be at the average rate calculated under Section 148.260 for those hospitals defined in 89 Ill. Adm. Code 149.50(c)(2).

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Section 148.270(c) (continued)

- 4) For long term stay hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(4), reimbursement for inpatient services shall be at the average rate calculated under Section 148.260 for those hospitals defined in 89 Ill. Adm. Code 149.50(c)(4).
- 5) For children's hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(3), reimbursement for inpatient services shall be at the average rate calculated under subsection (a) above for those hospitals defined in 89 Ill. Adm. Code 149.50(c)(3).

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 148.280 Reimbursement Methodologies for Children's Hospitals and Hospitals Reimbursed Under Special Arrangements

a) Children's Hospitals

1) Initial Rate Period

- A) For purposes of reimbursement, all children's hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(3), are grouped into one peer group.

- B) Each hospital's costs for the base period shall be derived from audited cost reports (see 42 CFR 447.260 and 447.265 (1982)) for hospital fiscal years ending during calendar year 1989.

- C) ~~In the event that an audited cost report is not available at the time rates are calculated, the unaudited report for the applicable period shall be used for the calculation of interim rates. Upon completion of the audit, the rates shall be recalculated. Payments made under the interim rate shall be reconciled.~~

- D) These base period costs shall be updated, trended forward, from the midpoint of each hospital's base period to the midpoint of the rate period for which rates are being set according to the methodology of the national total hospital market basket price proxies, (DRI).

- E) The children's hospitals' base period trended rates shall be used as the basis for calculating the group's median trended rate. Each individual hospital's trended rate is then compared to the group's median trended rate.

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Section 148.280(a)(1)(D) (continued)

Hospitals whose individual trended rates are higher than the median rates shall receive as a final inpatient payment rate their trended rate minus half the difference between their trended rate and the group's median trended rate.

Hospitals whose trended rates are lower than the group's median trended rate shall receive as its final inpatient payment rate their individual trended rate plus half the difference between their trended rate and the group's median trended rate.

2) Subsequent Rate Periods

For the rate period beginning on October 1, 1992, as described in Section 148.25(g)(1)(A), and for subsequent rate periods, as described in Section 148.25(g)(1)(B), the initial rate, as calculated under subsection (a)(1) above, ~~corrected according to the results of completed cost reports and audits~~, shall be updated from the midpoint of the base cost reporting period to the midpoint of the rate period using the national hospital market basket price proxies (DRI).

b) Hospitals Reimbursed Under Special Arrangements

Hospitals that, on August 31, 1991, had a contract with the Department under the ICARE Program, pursuant to Section 3-4 of the Illinois Health Finance Reform Act, may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care for services provided on or after September 1, 1991, subject to the limitations described in Sections 148.40(e) through 148.40(g).

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 148.290 Adjustments and Reductions to Total Payments

a) Applicable Adjustments for DSH and Uncompensated Care

The criteria and methodology for making applicable DSH and uncompensated care adjustments to hospitals ~~which are exempt from the DRG-PPS-89-111-Adm-149~~ shall be in accordance with Section 148.120 or, if applicable, Section 148.150.

b) Outlier Adjustments

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Section 148.290(b) (continued)

Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for certain individuals shall be made in accordance with Section 148.130 for hospitals that are exempt from the DRG PPS (see 89 Ill. Adm. Code 149).

c) Trauma Center Adjustments (TCA)

For inpatient admissions occurring on or after October 1, 1992, the Department shall make trauma center adjustments (TCA) to hospitals recognized, as of the first day of July preceding the TCA rate period, as Level I or Level II trauma centers by the Illinois Department of Public Health, or, if applicable, by the licensing agency in the State in which the hospital is located, in accordance with the provisions of subsections (c)(1) through (c)(5) below.

1) Level I Trauma Center Adjustment (TCA). Hospitals that, on the first day of July preceding the TCA rate period, meet the following criteria shall receive an adjustment of \$19,200.00 per Medicaid trauma admission in the TCA base period:

A) The hospital must not be a county-owned hospital, as described in Section 148.25(b)(1)(A), or a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B). The hospital is reimbursed under Sections 148.250 through 148.300 of 89 Ill. Adm. Code 149; and

B) The hospital must be recognized as a Level I trauma center by the Illinois Department of Public Health, or by the licensing agency in the State in which the hospital is located if the hospital is located within 50 miles of an Illinois border.

2) Level II Rural Trauma Center Adjustment (TCA). Illinois rural hospitals that meet the following criteria shall receive an adjustment of \$9,400.00 per Medicaid trauma admission in the TCA base period, on the first day of July preceding the rate period, are recognized as Level II trauma centers by the Illinois Department of Public Health shall receive an adjustment of \$9,400.00 per Medicaid trauma admission in the TCA base period.

A) With respect to the October 1, 1992, TCA rate period, on the first day of July preceding the TCA rate period, the hospital is located in a rural area and is recognized as a

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Section 148.290(c)(2)(A) (continued)

Level II trauma center by the Illinois Department of Public Health.

B) With respect to the October 1, 1993, TCA rate period, on July 14, 1993, the hospital is designated as a rural hospital, as defined in Section 148.25(g)(3), and is recognized as a Level II trauma center by the Illinois Department of Public Health.

C) With respect to TCA rate periods beginning on or after October 1, 1994, on the first day of July preceding the TCA rate period, the hospital is designated as a rural hospital, as defined in Section 148.25(g)(3), and is recognized as a Level II trauma center by the Illinois Department of Public Health.

3) Level II Urban Trauma Center Adjustment (TCA). Illinois urban hospitals, as described in Section 148.25(g)(4) for rate periods beginning on or after October 1, 1993, that, on the first day of July preceding the TCA rate period, are recognized as Level II trauma centers by the Illinois Department of Public Health shall receive an adjustment of \$9,400.00 per Medicaid trauma admission in the TCA base period, provided that such hospital meets the criteria described in subsections (c)(3)(B) or (c)(3)(C) below:

A) The Medicaid trauma admission percentage, as described in subsection (c)(7)(C) below, shall be calculated for each hospital described in subsection (c)(3) above. The trauma percentage shall be calculated by dividing each hospital's Medicaid trauma admissions by the total Medicaid trauma admissions for each hospital.

B) Each hospital described in subsection (c)(3) that meets the following additional criteria shall be eligible for the adjustment described in subsection (c)(3) above:

- i) The hospital is located in a county with no Level I trauma center;
- ii) The hospital has a Medicaid trauma admission percentage at or above the mean of the individual facility values determined in subsection (c)(3)(A) above; and
- iii) The hospital is located in a Health Manpower Shortage Area (HMSA) (42 CFR 5, 1989), as of the first day of

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Section 148.290(c)(3)(B)(iii) (continued)

July preceding the TCA rate period year.

- C) Each hospital described in subsection (c)(3) that meets the following additional criteria shall be eligible for the adjustment described in subsection (c)(3) above:

- i) The hospital is located in a county with no Level I trauma center; and
- ii) The hospital has a Medicaid trauma admission percentage that is at least the mean plus one standard deviation of the individual facility values determined in subsection (c)(3)(A) above.

- 4) County Trauma Center Adjustment (TCA). Illinois hospitals that, on the first day of July preceding the TCA rate period, are recognized as Level I or Level II trauma centers by the Illinois Department of Public Health, shall receive an adjustment that shall be calculated as follows:

- A) The available funds from the Trauma Center Fund for each quarter shall be divided by each eligible hospital's (as defined in subsection (c)(4) above) Medicaid trauma admissions in the same quarter of the TCA base period to determine the adjustment for the TCA rate base period. The result of this calculation shall be the County TCA adjustment per Medicaid trauma admission for the applicable quarter.

- B) The county trauma center adjustment payments shall not be treated as payments for hospital services under Title XIX of the Social Security Act for purposes of the calculation of the intergovernmental transfer provided for in Section 15-3(a) of the Public Aid Code.

- 5) Each eligible hospital's trauma center adjustment for the TCA rate period shall equal the sum of the amounts described in subsections (c)(1), (c)(2), (c)(3), and (c)(4)(A). The trauma center adjustments shall be paid to eligible hospitals on a quarterly basis.

- 6) Trauma Center Adjustment Limitations. Hospitals that qualify for trauma center adjustments under this subsection shall not be eligible for the total trauma center adjustment if, during the TCA rate period, the hospital is no longer recognized by the

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Section 148.290(c)(6) (continued)

Illinois Department of Public Health, or the appropriate licensing agency, as a Level I trauma center as required for the adjustment described in subsection (c)(1) above, a Level II trauma center as required for the adjustment described in subsection (c)(2) or (c)(3) above, or as a Level I or a Level II trauma center as required for the adjustment described in subsection (c)(4) above. In these instances, the adjustments calculated under this subsection shall be pro-rated, as applicable, based upon the date that such recognition ceased.

- 7) Trauma Center Adjustment Definitions. The definitions of terms used with reference to calculation of the trauma center adjustments required by subsection (c) are as follows:

- A) "Available funds" means that 97.5 percent of the funds available for distribution to the Department by the State Treasurer which have been deposited into the Trauma Center Fund, which have been distributed to the Department by the State Treasurer, and which have been appropriated by the Illinois General Assembly.

- B) "Medicaid trauma admission" means those claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the TCA rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 800.0 through 800.99, 801.0 through 801.99, 802.0 through 802.99, 803.0 through 803.99, 804.0 through 804.99, 805.0 through 805.99, 806.0 through 806.99, 807.0 through 807.99, 808.0 through 808.9, 809.0 through 809.1, 828.0 through 828.1, 839.0 through 839.3, 839.7 through 839.9, 850.0 through 850.9, 851.0 through 851.99, 852.0 through 852.59, 853.0 through 853.19, 854.0 through 854.19, 860.0 through 860.5, 861.0 through 861.32, 862.8, 863.0 through 863.99, 864.0 through 864.19, 865.0 through 865.19, 866.0 through 866.13, 867.0 through 867.9, 868.0 through 868.19, 869.0 through 869.1, 887.0 through 887.7, 896.0 through 896.3, 897.0 through 897.7, 900.0 through 900.9, 902.0 through 904.9, 925, 926.8, 929.0 through 929.99, 958.4, 958.5, 990 through 994.99. For those hospitals recognized as Level I trauma centers solely for pediatric trauma cases, Medicaid trauma admissions are only calculated for the claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the TCA rate period and

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Section 148.290(d)(3) (continued)

are as follows:

- A) "Medicaid Level I admissions" means those claims billed as Level I admissions, excluding admissions for normal newborns, which were subsequently adjudicated paid by the Department through the last day of June preceding the RHA rate period and contained within the Department's paid claims data base, with an occurrence code of 63 when applicable and an ICD-9-CM principal diagnosis code of: 054.3, 310.1 through 310.2, 320.1, 336.0 through 336.9, 344.0 through 344.2, 344.8 through 344.9, 348.1, 801.30, 803.10, 803.84, 806.0 through 806.19, 806.20 through 806.24, 806.26, 806.29 through 806.34, 806.36, 806.4 through 806.5, 851.06, 851.80, 853.05, 854.0 through 854.04, 854.06, 854.1 through 854.14, 854.16, 854.19, 905.0, 907.0, 907.2, 952.0 through 952.09, 952.10 through 952.16, 952.2, and V57.0 through V57.89.
- B) "RHA base period" means State Fiscal Year 1991, for RHA payments calculated for the October 1, 1992 RHA rate period, State Fiscal Year 1992 for RHA payments calculated for the October 1, 1993, RHA rate period, etc.
- C) "RHA rate period" means, beginning October 1, 1992, the 12 month period beginning on October 1 of the year and ending September 30 of the following year.

e) Perinatal Center Adjustments (PCA)

For inpatient admissions occurring on or after October 1, 1993, the Department shall make perinatal center adjustments (PCA) to hospitals in accordance with the provisions of subsections (e)(1) through (e)(3) below.

- 1) Hospitals that meet the following criteria shall receive an adjustment of \$825.00 per Medicaid perinatal admission in the PCA rate period:
- A) The hospital is designated as a Level II perinatal center by the Illinois Department of Public Health, or, if applicable, by the licensing agency in the State in which the hospital is located, on the first day of July preceding the PCA rate period;
- B) The hospital is:

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Section 148.290(e)(1)(B) (continued)

- i) With respect to the October 1, 1992, PCA rate period, located in a rural area on the first day of July preceding the PCA rate period;
- ii) With respect to the October 1, 1993, PCA rate period, designated as a rural hospital, as defined in Section 148.25(g)(3), on July 14, 1993;
- iii) With respect to PCA rate periods beginning on or after October 1, 1994, designated as a rural hospital, as defined in Section 148.25(g)(3), on the first day of July preceding the PCA rate period; and
- C) The hospital has a Medicaid perinatal percentage of 30 percent or above.
- 2) The perinatal center adjustments calculated under subsection (e)(1) above shall be paid to eligible hospitals on a quarterly basis.
- 3) Perinatal Center Adjustment Limitations. Hospitals that qualify for PCA adjustments under subsection (e)(1) above shall not be eligible for the total PCA adjustment if, during the PCA rate period, the hospital is no longer recognized or designated by the Illinois Department of Public Health, or the appropriate licensing agency, as a Level II perinatal center, as required by subsection (e)(1)(A) above. In this instance, the annual adjustment described in subsection (e)(1) above shall be pro-rated, as applicable, based upon the date that the designation ceased.
- 4) Perinatal Center Adjustment (PCA) Definitions. The definitions of terms used with reference to calculation of the perinatal center adjustments required by this subsection (e) are as follows:
- A) "Medicaid perinatal admissions", as referred to in subsection (e)(4)(D) below, means those claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the PCA rate period and contained within the Department's paid claims data base, for infants less than 29 days of age at the time of the admission with an ICD-9-CM diagnosis code within the ranges of 760 through 779 and V30 through V39, and those claims billed as admissions, excluding admissions for normal

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Section 148.290(e)(4)(A) (continued)

newborns, which were subsequently adjudicated by the Department through the last day of June preceding the PCA rate period and contained within the Department's paid claims data base, related to pregnancy, childbirth and the puerperium with an ICD-9-CM principal diagnosis code within the range of 630 through 676.

B) "Medicaid perinatal percentage" means a fraction, the numerator of which is the hospital's Medicaid perinatal admissions, and the denominator of which is the hospital's total Medicaid admissions.

C) "PCA base period" means State Fiscal Year 1992, for PCA payments calculated for the October 1, 1993, PCA rate period, State Fiscal Year 1993 for PCA payments calculated for the October 1, 1994, PCA rate period, etc.

D) "PCA rate period" means, beginning October 1, 1993, the 12 month period beginning on October 1 of the year and ending September 30 of the following year.

E) "Total Medicaid admissions", as referred to in subsection (e)(4)(B) above, means the total claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the PCA rate period and contained within the Department's paid claims data base.

C) Obstetrical Care Adjustments (OCA)

For inpatient admissions occurring on or after October 1, 1993, the Department shall make obstetrical care adjustments (OCA) to hospitals in accordance with the provisions of subsection (f)(1) below.

1) Hospitals that meet the following criteria shall receive an adjustment of \$675.00 per Medicaid obstetrical admission in the OCA rate period:

A) The hospital offers nonemergency obstetric procedures to the general public on the first day of July preceding the OCA rate period.

B) The hospital is:

i) With respect to the October 1, 1992, OCA rate period, located in a rural area on the first day of July

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Section 148.290(f)(1)(B)(i) (continued)

preceding the OCA rate period:

ii) With respect to the October 1, 1993, OCA rate period, designated as a rural hospital, as defined in Section 148.25(g)(3), on July 14, 1993:

iii) With respect to OCA rate periods beginning on or after October 1, 1994, designated as a rural hospital, as defined in Section 148.25(g)(3), on the first day of July preceding the OCA rate period; and

C) The hospital has a Medicaid obstetrical percentage of 20 percent or above.

2) The obstetrical care adjustments calculated under subsection (f)(1) above shall be paid to eligible hospitals on a quarterly basis.

3) Obstetrical Care Adjustment Limitations. Hospitals that qualify for OCA adjustments under subsection (f)(1) above shall not be eligible for the total OCA adjustment if, during the OCA rate period the hospital discontinues the provision of non-emergency obstetrical care. In this instance, the annual adjustment described in subsection (f)(1) shall be pro-rated, as applicable, based upon the date that the hospital discontinued the provision of such non-emergency obstetrical care.

4) Obstetrical Care Adjustment (OCA) Definitions. The definitions of terms used with reference to calculation of the obstetrical care adjustments required by subsection (f) are as follows:

A) "Medicaid obstetrical admissions", as referred to in subsection (f)(4)(B) below, means those claims billed as admissions, which were subsequently adjudicated by the Department through the last day of June preceding the OCA rate period and contained within the Department's paid claims data base, with an ICD-9-CM diagnosis code within the ranges of 650 and 669 which resulted in childbirth.

B) "Medicaid obstetrical percentage" means a fraction, the numerator of which is the hospital's Medicaid obstetrical admissions, and the denominator of which is the hospital's total Medicaid admissions.

C) "OCA base period" means State Fiscal Year 1992, for OCA payments calculated for the October 1, 1993, OCA rate

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Section 148.290(f)(4)(C) (continued)

period, State Fiscal Year 1993 for OCA payments calculated for the October 1, 1994, OCA rate period, etc.

D) "OCA rate period" means, beginning October 1, 1993, the 12 month period beginning on October 1 of the year and ending September 30 of the following year.

E) "Total Medicaid admissions", as referred to in subsection (f)(4)(B) above, means the total claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the OCA rate period and contained within the Department's paid claims data base.

g) Targeted Access Payment (TAP) Adjustments

For inpatient admissions occurring on or after October 1, 1993, the Department shall make targeted access payment (TAP) adjustments to Illinois hospitals in accordance with the provisions of subsections (g)(1) through (g)(8) below.

1) Criteria. To qualify for TAP adjustments under this subsection (g), hospitals must meet the following criteria:

A) With respect to the TAP adjustments described in subsections (g)(2) through (g)(6), the hospitals must be eligible to receive the adjustment payments described in Section 148.120(g)(2) in the TAP rate period:

B) With respect to the TAP adjustments described in subsections (g)(2) through (g)(6), the hospital must not be a county-owned hospital, as described in Section 148.25(b)(1)(A), or a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B);

C) With respect to the TAP adjustments described in subsections (g)(2), (g)(3) and (g)(5), and subject to subsection (g)(1)(E) below, the hospital must have 500 or fewer certificate of need beds if located in an urban area, as described in Section 148.25(g)(4). The number of certificate of need beds shall include total beds, excluding any used for substance abuse and/or long term care beds, and shall be determined by the Illinois Department of Public Health (IDPH), based upon the most

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Section 148.290(g)(1)(C) (continued)

current IDPH published report entitled "Bed Count, Average Length of Stay, Average Daily Census and Percent Occupancy for Non-Federal Hospitals in Illinois", which is available to the Illinois Department of Public Aid in the month immediately preceding the TAP rate period; and

D) With respect to the TAP adjustments described in subsections (g)(2), (g)(3) and (g)(5), and subject to subsection (g)(1)(E) below, the hospital must have 300 or fewer certificate of need beds if located in a rural area, as described in Section 148.25(g)(3). The number of certificate of need beds shall include total beds, excluding any used for substance abuse and/or long term care beds, and shall be determined by the Illinois Department of Public Health (IDPH), based upon the most current IDPH published report entitled "Bed Count, Average Length of Stay, Average Daily Census and Percent Occupancy for Non-Federal Hospitals in Illinois", which is available to the Illinois Department of Public Aid in the month immediately preceding the TAP rate period.

E) Notwithstanding the provisions of subsections (g)(1)(C) and (g)(1)(D), a children's hospital, as described in 148.120(a)(5), shall be eligible for the adjustments described in subsections (g)(2) and (g)(4). A children's hospital shall not be subject to or eligible for the adjustments described in subsections (g)(3), (g)(5) or (g)(6).

2) Medicaid Percentage Adjustment. Eligible hospitals, as described in subsection (g)(1) above, with a Medicaid inpatient utilization rate, as defined in Section 148.120(1)(5), of 35% or above shall receive an adjustment of \$70.00 per Medicaid admission in the TAP base year and all other eligible hospitals shall receive an adjustment per Medicaid admission in the TAP base year which is calculated by dividing the individual hospital's Medicaid inpatient utilization rate by 35% and multiplying the result by \$70.00.

3) Obstetrical Care Adjustment. Eligible hospitals, as described in subsection (g)(1) above, that provide nonemergency obstetrical services to the general public shall receive a TAP obstetrical care adjustment which shall include:

A) An adjustment of \$680.00 per Medicaid obstetrical admission in the TAP base period; and

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Section 148.290(g)(3) (continued)

B) An additional adjustment, up to \$340.00 per Medicaid obstetrical admission in the TAP base period, based upon the hospital's Medicaid obstetrical admission percentage. The additional adjustment shall be calculated by giving the hospital providing the most Medicaid obstetrical admissions a \$340.00 adjustment per Medicaid obstetrical admission in the TAP base period and all other qualifying hospitals an adjustment equal to the individual hospital's Medicaid obstetrical admission percentage divided by the Medicaid obstetrical admission percentage of the hospital with the highest Medicaid obstetrical admission percentage, the result of which shall then be multiplied by \$340.00.

4) Children's Care Adjustment. Eligible hospitals, as described in subsections (g)(1)(A) through (g)(1)(B) above, that provide services to children (defined as under the age of 18 and which excludes obstetrical services) shall receive a TAP children's care adjustment.

A) Eligible hospitals, as described in subsections (g)(1)(A), (g)(1)(B), and (g)(1)(E) above, shall receive a TAP children's care adjustment of up to \$600.00 per Medicaid children's admission in the TAP base period. The adjustment shall be calculated by dividing each eligible hospital's Medicaid children's admissions in the TAP base period by each eligible hospital's total Medicaid admissions in the TAP base period to arrive at the Medicaid children's admission percentage.

B) The hospital with the highest percentage of Medicaid children's admissions shall receive an adjustment of \$600.00 for each Medicaid children's admission in the TAP base period and all other qualifying hospitals shall receive an adjustment equal to \$600.00 multiplied by the individual hospital's Medicaid children's admission percentage divided by the Medicaid children's admission percentage of the hospital with the highest Medicaid children's admission percentage.

5) Ambulatory Care Network Adjustment. Eligible hospitals, as described in subsection (g)(1) above, shall complete and submit the Ambulatory Care Network Questionnaire in order to be considered for the TAP ambulatory care network adjustment. The Ambulatory Care Network Questionnaire must be received within 30 calendar days after receipt of notification from the Department that the information must be submitted. Information required in

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Section 148.290(g)(5) (continued)

this subsection (g) which is not received in compliance with this requirement shall not be considered for the determination of those hospitals qualified for ambulatory care network adjustments. In addition, such hospitals shall be required to enter into an agreement with the Department which describes in detail their involvements in ambulatory care, and includes commitments to maintain operations. Hospitals shall be required to notify the Department in advance of any action which would result in a reduction of 20 percent or more in the number of visits provided by hospital-operated primary care clinics or a reduction of 20 percent or more in the number of visits provided by primary care physicians. The TAP ambulatory care network adjustment shall consist of three possible individual adjustments as follows:

A) Hospitals reporting the following number of physician office visits on the Ambulatory Care Network Questionnaire shall receive the following adjustments per total Medicaid admissions in the TAP base period:

Urban Threshold	Rural Threshold	Adjustment
0 - 9,999	0 - 4,999	\$ 00.00
10,000 - 40,000	5,000 - 10,000	\$125.00
40,001 - 100,000	10,001 - 50,000	\$145.00
100,001 and over	50,001 and over	\$165.00

B) Hospitals qualifying for an adjustment under subsection (g)(5)(A) above shall receive an additional \$135.00 per total Medicaid admissions in the TAP base period if they have a formal linkage agreement with City of Chicago Partnerships in Health or Medicaid Partnerships.

C) Hospitals qualifying for an adjustment under subsection (g)(5)(A) above shall receive an additional \$135.00 per total Medicaid admissions in the TAP base period if they have a formal linkage agreement with a Federally Qualified Health Center, a County Health Clinic, or a Rural Health Clinic.

6) TAP Index Adjustment. With the exception of adjustments calculated in subsections (g)(2) and (g)(4) for children's hospitals, as described in Section 148.120(a)(5), the sum of the adjustments calculated in subsections (g)(2) through (g)(5) shall be multiplied by the following applicable percentages, which are based upon each hospital's Medicaid inpatient

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Section 148.290(g)(6) (continued)

utilization rate as defined in Section 148.120(1)(5):

- A) For those hospitals with a Medicaid inpatient utilization rate of 45 percent or above, the applicable percentage is 110 percent.
- B) For those hospitals with a Medicaid inpatient utilization rate of at least 25 percent, but less than 45 percent, the applicable percentage is 50 percent.
- C) For those hospitals with a Medicaid inpatient utilization rate of less than 25 percent, the applicable percentage is 25 percent.

7) The TAP adjustments calculated under subsections (g)(2) through (g)(6) above shall be paid to eligible hospitals on a quarterly basis.

8) Targeted Access Payment Adjustment Limitations.

Hospitals that qualify for TAP adjustments under subsection (g)(3) above shall not be eligible for the total TAP adjustment if, during the TAP rate period:

- A) The hospital discontinues the provision of non-emergency obstetrical care. In this instance, the annual adjustment described in subsections (g)(3) and (g)(6) shall be pro-rated, as applicable, based upon the date that the hospital discontinued the provision of such non-emergency obstetrical care.
- B) The hospital does not honor its commitment to maintain operations as required in subsection (g)(5) of this Section. In the event that there is a reduction of 20 percent or more in the number of visits provided by hospital-operated primary care clinics or a reduction of 20 percent or more in the number of visits provided by primary care physicians, the Department may, subject to approval by the Director, deem the hospital ineligible for the adjustments described in subsections (g)(5) and (g)(6) of this Section, either in total or in part.
- C) The hospital discontinues its formal linkage agreements required in subsections (g)(5)(B) and (g)(5)(C). In this instance, the annual adjustment described in subsections

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Section 148.290(g)(8)(C) (continued)

(g)(5) and (g)(6) shall be pro-rated based upon the date that the formal linkage agreement(s) was discontinued.

9) Targeted Access Payment (TAP) Adjustment Definitions. The definitions of terms used with reference to calculation of the targeted access payment adjustments required by subsection (g) are as follows:

- A) "Medicaid children's admission" means those claims billed as admissions of an individual under 18 years of age, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the TAP rate period and contained within the Department's paid claims data base, but excludes those claims billed as admissions with an ICD-9-CM principal diagnosis code within the range of 650 and 669 (indicating an obstetrical admission).
- B) "Medicaid obstetrical admission" means those claims billed as admissions, which were subsequently adjudicated by the Department through the last day of June preceding the TAP rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code within the ranges of 650 and 669 which resulted in childbirth.
- C) "Medicaid obstetrical admission percentage" means a fraction, the numerator of which is the hospital's Medicaid obstetrical admissions, and the denominator of which is the Medicaid obstetrical admissions provided by all hospitals qualified for the TAP obstetrical care adjustment.
- D) "Medicaid perinatal percentage" means a fraction, the numerator of which is the hospital's Medicaid perinatal admissions, and the denominator of which is the hospital's total Medicaid admissions.
- E) "TAP base period" means State Fiscal Year 1992, for TAP payments calculated for the October 1, 1993, TAP rate period, State Fiscal Year 1993 for TAP payments calculated for the October 1, 1994, TAP rate period, etc.
- F) "TAP rate period" means, beginning October 1, 1993, the 12 month period beginning on October 1 of the year and ending September 30 of the following year.

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Section 148.290(g)(9) (continued)

- g) "Total Medicaid admissions", as referred to in subsection (g)(9)(D) above, means the total claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the TAP rate period and contained within the Department's paid claims data base.

h) Medicaid High Volume Adjustments (MHVA)

For inpatient admissions occurring on or after October 1, 1993, the Department shall make Medicaid High Volume Adjustments (MHVA) to hospitals in accordance with the provisions of subsection (h)(1) through (h)(2) below.

- 1) Criteria. To qualify for MHVA adjustments under this subsection (h), hospitals must meet the following criteria:

A) With respect to the MHVA described in subsection (h)(2)(A) through (h)(2)(C), the hospitals must:

- i) Be eligible to receive the adjustment payments described in Section 148.120 in the MHVA rate period; and
- ii) Not be a county-owned hospital, as described in Section 148.25 (b)(1)(A), or a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25 (b)(1)(B) in the MHVA rate period.

B) With respect to the MHVA adjustments described in subsection (h)(2)(D):

- i) The hospital must not be eligible to receive the adjustment payments described in Section 148.120 (g)(2) in the MHVA rate period;
- ii) The total number of Medicaid inpatient days as defined in subsection (h)(4)(D) of this Section, provided by each Medicaid participating Illinois hospital, must be at least one standard deviation above the mean number of Medicaid inpatient days, as defined in subsection (h)(4)(A) of this Section for the MHVA base fiscal year; and

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Section 148.290(h)(1)(B) (continued)

- iii) The hospital must meet the requirements of subsection (h)(1)(D) below when located in a geographic area covered by the managed care component of the Healthy Moms/Healthy Kids Program, as described in 89 Ill. Adm. Code 140.928(a)(1).

C) Source of Data. In making the determination described in subsection (h)(1)(B)(ii) above, the Department shall utilize:

- i) The hospital's final audited cost report for the hospital's MHVA base fiscal year. Medicaid inpatient days, as defined in subsection (h)(4)(D) of this Section, which have been derived from final audited cost reports, are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation.

- ii) In the absence of a final audited cost report for the hospital's MHVA base fiscal year, the Department shall utilize the hospital's unaudited cost report for the hospital's MHVA base fiscal year. Due to the unaudited nature of this information, hospitals shall have the opportunity to submit a corrected cost report for the determination described in subsection (h)(1)(B)(ii) above. Submittal of a corrected cost report in support of subsection (h)(1)(B)(ii) above must be received no later than the first day of July preceding the MHVA rate period for which the hospital is requesting consideration of such corrected cost report for the determination of MHVA qualification. Corrected cost reports which are not received in compliance with these time limitations will not be considered for the determination of the hospital's Medicaid inpatient days as described in subsection (h)(4)(D) of this Section.

- iii) Hospitals' Medicaid inpatient days, as defined in subsection (h)(4)(D) of this Section, which have been derived from unaudited cost reports, are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation. Pursuant to subsection (h)(1)(C)(ii) above, hospitals shall have the opportunity to submit corrected cost report information prior to the Department's MHVA determination.

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Section 148.290(h)(1)(C) (continued)

- iv) In the event a subsequent final audited cost report reflects Medicaid inpatient days, as described in subsection (h)(4)(D) of this Section, which are lower than the Medicaid inpatient days derived from the unaudited cost report utilized for the MHVA determination, the Department shall recalculate the Medicaid inpatient days based upon the final audited cost report, and recoup any overpayments made.
- D) Hospitals meeting the criteria described in subsection (h)(1)(B) above, that are located in a geographic area covered by the managed care component of the Healthy Moms/Healthy Kids Program, as described in 89 Ill. Adm. Code 140.928(a)(1), must meet the following requirements:
- i) Hospitals designated as Level III perinatal centers by the Illinois Department of Public Health must enter into an agreement with the Department to participate in the Healthy Moms/Healthy Kids Program as a Certified Obstetrical Ambulatory Care Center (COBACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(C), with a minimum Healthy Moms/Healthy Kids client assignment capacity commitment that includes a specified minimum number of pregnant women determined to be at medical high risk of abnormal delivery, and is otherwise mutually agreeable to both the Department and the hospital;
 - ii) Hospitals that are not designated as Level III perinatal centers by the Illinois Department of Public Health must enter into an agreement or agreements with the Department to participate in the Healthy Moms/Healthy Kids Program as a Certified Hospital Ambulatory Primary Care Center (CHAPCC), as described in 89 Ill. Adm. Code 140.461(f)(1)(A), and/or a Certified Hospital Organized Satellite Clinic (CHOSC), as described in 89 Ill. Adm. Code 140.461(f)(1)(B), with a minimum total Healthy Moms/Healthy Kids client assignment capacity commitment that is otherwise mutually agreeable to both the Department and the hospital; and
 - iii) Hospitals must enter into the agreements described in subsections (h)(1)(D)(i) and (h)(1)(D)(ii) above by the first day of January in the MHVA rate period.

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Section 148.290(h) (continued)

- 2) Calculation of Medicaid High Volume Adjustments
- A) Hospitals meeting the criteria specified in subsection (h)(1)(A) above shall receive a MHVA payment adjustment of \$60.
 - B) For children's hospitals, as defined in Section 148.120 (a)(5), the payment adjustment calculated under subsection (h)(2)(A) above shall be multiplied by 2.0.
 - C) The amount calculated pursuant to subsections (h)(2)(A) and (h)(2)(B) above shall be adjusted on October 1, 1993, and annually thereafter, by a percentage equal to the lesser of:
 - i) The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent 12 month period for which data are available; or
 - ii) The percentage increase in the statewide average hospital payment rate, as described in subsection (h)(4)(E) of this Section, over the previous year's statewide average hospital payment rate.
 - D) Hospitals meeting the criteria specified in subsections (h)(1)(B) and (h)(1)(D) above shall receive an add-on payment to their inpatient rate.
 - i) The distribution method for the add-on payment described in subsection (h)(2)(D) above is based upon a fund of \$12 million. All hospitals qualifying under subsections (h)(1)(B) and (h)(1)(D) above will receive an \$85 per day add-on to their current rate. The total cost of this adjustment is calculated by multiplying each hospital's most recent completed fiscal year Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) by \$85. The total dollar amount of this calculation is then subtracted from the \$12 million fund.
 - ii) The remaining fund balance is then distributed to the hospitals that are located in a geographical area covered by the managed care component of the Healthy Moms/Healthy Kids Program as described in 89 Ill. Adm. Code 140.928(a)(1) in proportion to the percentage by which the hospital's Medicaid inpatient days, as

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Section 148.290(h)(2)(D)(ii) (continued)

described in subsection (h)(4)(D), exceeds one standard deviation above the State's mean Medicaid inpatient days, as described in subsection (h)(4)(A) of this Section. This is done by finding the ratio of each qualified hospital's percent Medicaid inpatient days to the State's mean plus one standard deviation percent Medicaid inpatient days value. These ratios are then summed and each qualified hospital's proportion of the total is calculated. These proportional values are then multiplied by each qualified hospital's most recent completed fiscal year Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization). These weighted values are summed and each qualified hospital's proportion of the summed weighted value is calculated. Each individual qualified hospital's proportional value is then multiplied against the \$12 million pool of money available after the \$85 per day base add-on has been subtracted.

iii) The total dollar amount calculated for each qualifying hospital under subsection (h)(2)(D)(ii) above (plus the initial \$85 per day add-on amount calculated for each qualifying hospital under subsection (h)(2)(D)(i) above) is then divided by the Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) to arrive at a per day add-on value. Hospitals meeting the criteria described under subsection (h)(1)(B)(ii), that are not located in a geographical area covered by the managed care component of the Healthy Moms/Healthy Kids Program, as described in 89 Ill. Adm. Code 140.928(a)(1), will receive the minimum adjustment of \$85 per inpatient day. The adjustments calculated under this subsection are subject to the limitations described in subsection (h)(3) below.

E) The adjustments calculated under subsections (h)(2)(A) through (h)(2)(D) of this Section shall be paid on a per diem basis and shall be applied to each covered day of care provided.

J) Medicaid High Volume Adjustment Limitations.

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Section 148.290(h)(3) (continued)

A) Hospitals located in a geographic area covered by the managed care component of the Healthy Moms/Healthy Kids Program, as described in 89 Ill. Adm. Code 140.928(a)(1), that qualify for MHVA adjustments under subsection (h)(2)(D) above, shall not be eligible for the MHVA adjustment if:

i) The hospital does not enter into a Healthy Moms/Healthy Kids agreement, as required in subsections (h)(1)(D)(i) and (h)(1)(D)(ii) above, by the first day of January of the MHVA rate period. In this instance, any adjustments described in subsection (h)(2)(D) that have been made by the Department shall be recouped and the hospital shall no longer be deemed eligible for the MHVA adjustment.

ii) The hospital does not honor its minimum Healthy Moms/Healthy Kids client assignment capacity commitment, as described in subsections (h)(1)(D)(i) and (h)(1)(D)(ii) of this Section. In this instance, the Department may, subject to approval by the Director, deem the hospital ineligible for the adjustments described in subsection (h)(2)(D) of this Section, either in total or in part.

B) Hospitals that qualify for MHVA adjustments under subsections (h)(2)(A) through (h)(2)(C) above shall not be eligible for such MHVA adjustments if they are no longer recognized or designated by the Department as a DSH hospital, as required by subsection (h)(1)(A)(i). In this instance, the annual adjustment described in subsections (h)(2)(A) through (h)(2)(C) shall be pro-rated, as applicable, based upon the date that the hospital was deemed ineligible for DSH payments adjustments, under Section 148.120, by the Department.

C) In no instance shall the final aggregate MHVA payment adjustments calculated under subsection (h)(2)(D)(i) above for all hospitals exceed \$12 million. In the event that aggregate MHVA payment adjustments calculated under subsection (h)(2)(D)(i) exceed \$12 million, each hospital's MHVA payment adjustment calculated under subsection (h)(2)(D)(i) above shall be adjusted proportionately to ensure that the final aggregate MHVA payment adjustments calculated under subsection (h)(2)(D)(i) above for all hospitals do not exceed \$12 million.

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Section 148.290(h) (continued)

- 4) Medicaid High Volume Adjustment Definitions. The definitions of terms used with reference to calculation of the MHVA adjustments required by subsection (h) are as follows:

A) "Mean Medicaid inpatient days" means a fraction the numerator of which is the total number of inpatient days provided in a given 12 month period by all Medicaid participating Illinois hospitals to patients who, for such days, were eligible for Medicaid under Title XIX under the Federal Social Security Act (42 U.S.C. Sec. 1396a et seq.) and the denominator of which is the total number of all Medicaid participating Illinois hospitals. Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) and Aid to the Medically Indigent (AMI) days but does include the types of days described in Section 148.120(c)(3). In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

B) "MHVA base fiscal year" means, for example, the hospital's fiscal year ending in 1991 for the October 1, 1993, MHVA determination year, the hospital's fiscal year ending in 1992 for the October 1, 1994, MHVA determination year, etc.

C) "MHVA rate period" means, beginning October 1, 1993, the 12 month period beginning on October 1 of the year and ending September 30 of the following year.

D) "Medicaid inpatient days" means the total number of inpatient days provided in a given 12 month period by each hospital to patients who, for such days, were eligible for Medicaid under Title XIX under the Federal Social Security Act (42 U.S.C. Sec. 1396a et seq.). Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) and Aid to the Medically Indigent (AMI) days but does include the types of days described in Section 148.120(c)(3). In this subsection (h)(4)(D), the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual

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Section 148.290(h)(4)(D) (continued)

remains in the hospital for lack of suitable placement elsewhere.

E) "Statewide Average Hospital Payment Rate" means the hospital's alternative reimbursement rate, as defined in Section 148.270(a).

1) Inpatient Payment Adjustments based upon Reviews. Appeals based upon a hospital's ineligibility for the inpatient payment adjustments described in this Section, or their payment adjustment amounts, in accordance with Section 148.310, which result in a change in a hospital's eligibility for inpatient payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the inpatient payment adjustments of any other hospital or the payment adjustment amount of any other hospital that has received notification from the Department of their eligibility for inpatient payment adjustments based upon the requirements of this Section.

2) Reductions to Total Payments

1) Copayments. Copayments are assessed under all medical programs administered by the Department except the Children and Family Assistance Program, formerly known as the General Assistance medical program, and shall be assessed in accordance with Section 148.190.

2) Third Party Payments. Hospitals shall determine that services are not covered, in whole or in part, under any program or under any other private group indemnification or insurance program, health maintenance organization, workers compensation or the tort liability of any third party. To the extent that such coverage is available, the Department's payment obligation shall be reduced.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 148.310 Review Procedure

a) Inpatient Rate Reviews

1) Hospitals shall be notified of their inpatient rate for the rate year and shall have an opportunity to request a review of the rate for errors in calculation. Such a request must be received in writing by the Department within 30 days of after the date of the Department's notice to the hospital of their rates. The

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Section 148.310(a)(1) (continued)

Department shall notify the hospital of the results of the review within 30 days of after receipt of the hospital's request for review.

- 2) Hospitals reimbursed in accordance with Sections 148.250 through 148.300 and 89 Ill. Adm. Code 149 with respect to per diem add-ons for capital, medical education and CRNA costs, may request that an adjustment be made to their base year costs to reflect significant changes in costs which have been mandated in order to meet State, federal or local health and safety standards, and which have occurred since the hospital's filing of the base year cost report. The allowable Medicare/Medicaid costs must be identified from the most recent audited cost report available. These costs must be significant, i.e., on a per unit basis, they must constitute one percent or more of the total allowable Medicaid/Medicare unit costs for the same time period. Appeals for base year cost adjustments must be received, in writing, by the Department within 30 days of after the date of the Department's notice to the hospital of their rates. Such request shall include a clear explanation of the cost change and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days of after receipt of the hospital's request for review.

- 3) Primary Care Access Health Care Education Payment Reviews. Hospitals reimbursed in accordance with 89 Ill. Adm. Code 149.140, with respect to per discharge add-ons for primary care access health care education payments, shall:

- A) Be notified of their per discharge add-on amount for the rate period and shall have an opportunity to request a review of the per discharge add-on amount for errors in calculation. Such a request must be received in writing by the Department within 30 days after the date of the Department's notice to the hospital of their per discharge add-on amount. Such request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.
- B) Be notified of any adjustments that shall be made to their per discharge add-on amount for the rate period as a result of the requirements of 89 Ill. Adm. Code 149.140, and shall have an opportunity to request a review of such adjustment.

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Section 148.310(b)(3)(B) (continued)

determinations for errors in calculation. Such a request must be received in writing by the Department within 30 days after the date of the Department's notice to the hospital of adjustment amounts. Such a request shall include a clear explanation of reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

b) DSH Determination Reviews

- 1) Hospitals shall be notified of their qualification for DSH payment adjustments and shall have an opportunity to request a review of the DSH add-on for errors in calculation. Such a request must be received in writing by the Department within 30 days of after the date of the Department's notice to the hospital of its disproportionate share qualification and add-on calculations. Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days of after receipt of the hospital's request for review.
- 2) DSH determination reviews shall be limited to the following:
- A) DSH Determination Criteria. The criteria for DSH determination shall be in accordance with Section 148.120. Review shall be limited to verification that the Department utilized criteria in accordance with State regulations.
- B) Medicaid Inpatient Utilization Rates. Medicaid inpatient utilization rates shall be calculated pursuant to Section 1923 of the Social Security Act and as defined in Section 148.120(a)(1)(i)(5). Review shall be limited to verification that Medicaid inpatient utilization rates were calculated in accordance with federal and State regulations.
- C) Low Income Utilization Rates. Low income utilization rates shall be calculated in accordance with Section 1923 of the Social Security Act and Section 148.120(a)(2) and (d). Review shall be limited to verification that low income utilization rates were calculated in accordance with federal and State regulations.
- D) Federally Designated Health Manpower Shortage Areas

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Section 148.310(b)(2)(D) (continued)

(HMSAs). Illinois hospitals located in federally designated HMSAs shall be identified in accordance with 42 CFR 5, 1989, and Section 148.120(a)(3) based upon the methodologies utilized by, and the most current information available to the Department, from the Department of Health and Human Services as of July 1, 1991, June 30, 1992, -- For the period July 1, 1992, through September 30, 1992, Illinois hospitals located in federally designated HMSAs shall be identified in accordance with 42 CFR 5, 1989, and Section 148.120(a) and 148.120(a)(3) based upon the methodologies utilized by, and the most current information available to the Department of Health and Human Services as of June 30, 1992. Review shall be limited to hospitals in locations that have failed to obtain designation as federally designated HMSAs only when such a request for review is accompanied by documentation from the Department of Health and Human Services substantiating that the hospital was located in a federally designated HMSA as of July 1, 1991 or if applicable, as of June 30, 1992. -- The provisions of this subsection shall no longer apply effective on or after October 1, 1992.

E) Excess Beds. Excess bed information shall be determined in accordance with Public Act 86-268 (Code Section 148.120(a)(3) and 77 Ill. Adm. Code 1100) based upon the methodologies utilized by, and the most current information available to, the Illinois Health Facilities Planning Board as of July 1, 1991. Reviews shall be limited to requests accompanied by documentation from the Illinois Health Facilities Planning Board substantiating that the information supplied to and utilized by the Department was incorrect. -- The provisions of this subsection shall no longer apply effective on or after October 1, 1992.

F) Medicaid Obstetrical Inpatient Utilization Rates. Medicaid obstetrical inpatient utilization rates shall be calculated in accordance with Section 148.120(a)(4), (a)(9), (a)(10) and (a)(15)(1)(4), (1)(6) and (1)(7). Review shall be limited to verification that Medicaid obstetrical inpatient utilization rates were calculated in accordance with State regulations.

G) TAP Adjustments.

i) Medicaid Percentage. -- Medicaid inpatient utilization rates shall be calculated in accordance with Section

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Section 148.310(b)(2)(G)(i) (continued)

148.120(a)(1) and (3)(2). -- Review shall be limited to verification that Medicaid inpatient utilization rates were calculated in accordance with State regulations.

ii) Medicaid Obstetrical Admission Percentage. -- Medicaid obstetrical admission percentage shall be calculated in accordance with Section 148.120(j)(3) and (a)(11). Review shall be limited to verification that Medicaid obstetrical admission percentages were calculated in accordance with State regulations.

iii) Medicaid Children's Admission Percentage. -- Medicaid children's admission percentage shall be calculated in accordance with Section 148.120(j)(4), (a)(3) and (a)(6). -- Review shall be limited to verification that Medicaid children's admission percentages were calculated in accordance with State regulations.

iv) TAP Bed Limits. -- The TAP bed limits described in Section 148.120-(3)(2)(A)(i), (3)(2)(A)(ii), (3)(2)(A)(iii), (3)(2)(A)(iv), (3)(5)(A)(ii) shall be determined in accordance with such subsections, and review shall be limited to verification that these TAP bed limits were determined in accordance with such subsections.

H) CCA Payment Adjustments.

i) Medicaid Perinatal Percentage. -- Medicaid perinatal percentage shall be calculated in accordance with Section 148.120(6)(A), (a)(12) and (a)(16). -- Review shall be limited to verification that perinatal percentages were calculated in accordance with State regulations.

ii) Medicaid Obstetrical Percentage. -- Medicaid obstetrical percentage shall be calculated in accordance with Section 148.120(a)(6)(B), (a)(11) and (a)(16). -- Review shall be limited to verification that obstetrical percentages were calculated in accordance with State regulations.

c) Outlier Adjustment Reviews

The Department shall make outlier adjustments to payment amounts in accordance with 89 Ill. Adm. Code 149.105 or Section 148.130.

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Section 148.310(c) (continued)

whichever is applicable. Hospitals shall be notified of the specific information which shall be utilized in the determination of those services qualified for an outlier adjustment and shall have an opportunity to request a review of such specific information for errors in calculation only. Such a request must be received in writing by the Department within 30 days of the date of the Department's notice to the hospital of the specific information which shall be utilized in the determination of those services qualified for an outlier adjustment. Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days of after receipt of the hospital's request for review.

d) Cost Report Reviews

1) Cost reports are required from:

- A) All all enrolled hospitals within the State of Illinois;
- B) All all out-of-state hospitals providing 100 inpatient days of service per hospital fiscal year, to persons covered by the Illinois Medical Assistance Program; and
- C) All all hospitals not located in Illinois that elect to be reimbursed under the methodology described in 89 Ill. Adm. Code 149 (the DRG PPS).

- 2) The completed cost statement with a copy of the hospital's Medicare cost report and audited financial statement must be submitted annually within 90 days of the close of the hospital's fiscal year. A one-time 30-day extension may be requested. Such a request for an extension shall be in writing and shall be received by the Department's Office of Health Finance prior to the end of the 90-day filing period. The Office of Health Finance shall audit the information shown on the Hospital Statement of Reimbursable Cost and Support Schedules. The audit shall be made in accordance with generally accepted auditing standards and shall include tests of the accounting and statistical records and applicable auditing procedures. Hospitals shall be notified of the results of the final audited cost report which may contain adjustments and revisions which may have resulted from the audited Medicare Cost Report. Hospitals shall have the opportunity to request a review of the final audited cost report. Such a request must be received in writing by the Department within 45 days of after the date of

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Section 148.310(d)(2) (continued)

the Department's notice to the hospital of the results of the finalized audit. Such request shall include all items of documentation and analysis which support the request for review. No additional data shall be accepted after the 45 day period. The Department shall notify the hospital of the results of the review within 30 days of after receipt of the hospital's request for review.

e) Uncompensated Care Adjustment Reviews

The Department shall make uncompensated care adjustments in accordance with Section 148.150. Hospitals shall have the right to appeal the uncompensated care rate calculation or their ineligibility for the uncompensated care rate adjustment if it is believed that a technical error has been made in the calculation. The appeal must be in writing and must be received within 30 days of after the date of the Department's notice to the hospital of its qualification for uncompensated care adjustments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for the uncompensated care payment adjustment. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days of after receipt of the hospital's request for review.

f) Trauma Center Adjustment Reviews

- 1) The Department shall make trauma care adjustments in accordance with Section 148.290(c). Hospitals shall have the right to appeal the trauma center adjustment calculations if it is believed that a technical error has been made in the calculation. The appeal must be in writing and must be received within 30 days of the date of the Department's notice to the hospital of its qualification for uncompensated care adjustments and payment amounts. The Department shall notify the hospital of the results of the review within 30 days of receipt of the hospital's request for review.
- 2) Illinois hospitals located in federally designated HMSAs shall be identified in accordance with 42 CFR 5. 1989, based upon the methodologies utilized by, and the most current information available to, the Department from the Department of Health and Human Services as of the first day of July preceding the trauma center adjustment rate period. Review shall be limited to hospitals in locations that have failed to obtain designation as federally designated HMSAs only when such a request for review

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Section 148.310(f)(2) (continued)

is accompanied by documentation from the Department of Health and Human Services substantiating that the hospital was located in a federally designated HMSA as of the first day of July preceding the trauma center adjustment rate period.

- 3) Trauma level designation is obtained from the Illinois Department of Public Health as of the first day of July preceding the trauma center adjustment rate period. Review shall be limited to requests accompanied by documentation from the Illinois Department of Public Health, or the licensing agency in the state in which the hospital is located, substantiating that the information supplied to and utilized by the Department was incorrect.

- 4) Appeals under subsection (f) must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for trauma center adjustments and payment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

g) Rehabilitation Hospital Adjustment Reviews

The Department shall make rehabilitation hospital adjustments in accordance with Section 148.290(d). Hospitals shall have the right to appeal the rehabilitation hospital adjustment calculations if it is believed that a technical error has been made in the calculation. The appeal must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for rehabilitation hospital adjustments and payment adjustment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

h) Perinatal Center Adjustment Reviews

- 1) Medicaid Perinatal Percentage. Medicaid perinatal percentage shall be calculated in accordance with Section 148.290(e). Review shall be limited to verification that perinatal percentages were calculated in accordance with State regulations.

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Section 148.310(h) (continued)

- 2) Perinatal level designation is obtained from the Illinois Department of Public Health as of the first day of July preceding the perinatal center adjustment rate period. Review shall be limited to requests accompanied by documentation from the Illinois Department of Public Health, or the licensing agency in the state in which the hospital is located, substantiating that the information supplied to and utilized by the Department was incorrect.

- 3) Appeals under this subsection (h) must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for perinatal center adjustments and payment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

i) Obstetrical Care Adjustment Review

Medicaid Obstetrical Percentage. Medicaid obstetrical percentage shall be calculated in accordance with Section 148.290(f). Review shall be limited to verification that Medicaid obstetrical percentages were calculated in accordance with State regulations. The appeal must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for obstetrical care adjustments and payment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

j) TAP Adjustments

- 1) Medicaid Percentage. Medicaid inpatient utilization rates shall be calculated in accordance with Section 148.120(1)(5). Review shall be limited to verification that Medicaid inpatient utilization rates were calculated in accordance with State regulations.

- 2) Medicaid Obstetrical Admission Percentage. Medicaid obstetrical admission percentage shall be calculated in accordance with Section 148.290(g)(3). Review shall be limited to verification that Medicaid obstetrical admission percentages were calculated in accordance with State regulations.

Section 148.310(j) (continued)

- 3) Medicaid Children's Admission Percentage. Medicaid children's admission percentage shall be calculated in accordance with Section 148.290(g)(4). Review shall be limited to verification that Medicaid children's admission percentages were calculated in accordance with State regulations.
- 4) TAP Bed Limits. The TAP bed limits described in Section 148.290 (g)(1)(C) and (g)(1)(D) shall be determined in accordance with such subsections, and review shall be limited to verification that these TAP bed limits were determined in accordance with such subsections.
- 5) Appeals under subsection (j) of this Section must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for targeted access adjustments and payment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

k) Medicaid High Volume Adjustment Reviews

The Department shall make Medicaid high volume adjustments in accordance with Section 148.290(h). Review shall be limited to verification that the Medicaid inpatient days were calculated in accordance with State regulations. The appeal must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid high volume adjustments and payment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

l) Sole Community Hospital Designation Reviews

The Department shall make sole community hospital designations in accordance with 89 Ill. Adm. Code 149.125(b). Hospitals shall have the right to appeal the designation if it is believed believes that a technical error has been made in the determination. The appeal must be made in writing and must be received within no-later-than 30 days after notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

Section 148.310 (continued)

m) Geographic Designation Reviews

- 1) The Department shall make rural hospital designations in accordance with Section 148.25(g)(3). Hospitals shall have the right to appeal the designation if it is believed that a technical error has been made in the determination. The appeal must be in writing and must be received within 30 days after notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.
- 2) The Department shall make urban hospital designations in accordance with Section 148.25(g)(4). Hospitals shall have the right to appeal the designation if it is believed that a technical error has been made in the determination. The appeal must be in writing and must be received within 30 days after notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

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1) Heading of the Part: Medical Payment2) Code Citation: 89 Ill. Adm. Code 1403) Section Numbers: Adopted Action:

140.2, 140.12, 140.40,	Amendment
140.71, 140.80, 140.82,	Amendment
140.84, 140.400, 140.413,	Amendment
140.460, 140.461, 140.462,	Amendment
140.463, 140.464, 140.485,	Amendment
140.523	
140.920, 140.922, 140.924,	New Section
140.926, 140.928, 140.930,	New Section
140.932, 140. Table M	New Section

4) Statutory Authority: Articles III, IV, V, VI, VII and Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1991, ch. 23, pars. 3-1 et seq., 4-1 et seq., 5-1 et seq., 6-1 et seq., 7-1 et seq., and 12-13) [305 ILCS 5/Arts. 3, 4, 5, 6, 7 and 5/12-13], Public Act 87-861, effective July 8, 1992, Public Act 88-85, effective July 14, 1993, and Public Act 88-88, effective July 14, 1993.5) Effective Date of Amendments: February 28, 19946) Does this rulemaking contain an automatic repeal date? No7) Do these Amendments contain incorporations by reference? No8) Date Filed in Agency's Principal Office: February 28, 19949) Notice of Proposal Published in Illinois Register:

Sections 140.2 through 140.485, 140.523 and Sections 140.920 through Table M

October 22, 1993 (17 Ill. Reg. 18436)

Sections 140.71 through 140.84

October 15, 1993 (17 Ill. Reg. 17736)

10) Has JCAR issued a Statement of Objections to these Adopted Amendments? No11) Differences between proposal and final version: The following changes have been made in the proposed amendments.

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Section 140.2

Subsection (a) has been revised by the addition "; and" at the end of (6), and the addition of a new (7), which reads:

- (7) noncitizens who have an emergency medical condition (see 89 Ill. Adm. Code 120.310); however, payment is not included for care and services related to an organ transplant procedure.

Section 140.12

Subsection (j) has been revised to read:

- (j) Complete a Healthy Moms/Healthy Kids Provider Agreement in order to participate in the Healthy Moms/Healthy Kids Program (see Section 140.924(a)(1)(D)).

Section 140.80

In subsection (d)(5) all references to "tax" have been changed to read "assessment".

In subsection (d)(6) after the word "agent" in line two, insert "within three years after the end of the fiscal year in which the assessment was due". Additionally, all references to "tax" have been changed to read "assessment".

In subsection (e)(1), the word "tax" in line one has been changed to read "assessment".

In subsection (e)(2) the word "tax" in line one has been changed to read "assessment".

In subsection (f)(2), line four, the reference to "provider fee" has been changed to read "assessment".

In subsection (g) the word "fees" in line one has been changed to read "assessments".

In subsection (g)(2) the word "fee" in line four has been changed to read "assessment".

In subsection (h) all references to "fees" or "fee" have been changed to read "assessments" or "assessment".

In subsection (h)(1)(D), line two, reference to "provider participation fee funds" has been changed to read "assessment funds".

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In subsection (h)(3)(A), line 16, in the sentence beginning "Requests must be complete and contain all required...", the word "payment" has been inserted between "delayed" and "request".

In subsection (1)(1), all references to "tax" have been changed to read "assessment".

Section 140.82

In subsection (d)(4), two spaces have been inserted before the sentence beginning with "penalties may be applied ...".

In subsection (d)(5), all references to "tax" have been changed to read "assessment".

In subsection (d)(6) after the word "agent" in line two, insert "within three years after the end of the fiscal year in which the assessment was due". Additionally, all references to "tax" have been changed to read "assessment".

In subsection (e)(1), the word "tax" in line one has been changed to read "assessment".

In subsection (e)(2) the word "tax" in line one has been changed to read "assessment".

In subsection (f)(2), line four, the reference to "provider fee" has been changed to read "assessment".

In subsection (f)(3), the word "fee" in line four has been changed to read "assessment".

In subsection (g) the word "fees" has been changed to read "assessments".

In subsection (g)(2) the word "fee" has been changed to read "assessment".

In subsection (h) the word "fees" in line two has been changed to read "assessments".

In subsection (h)(1)(C), line two, the word "request" has been corrected to read "request".

Section 140.84

In subsection (b) in the sentence beginning "All beds subject to licensure...", the words "nursing home" have been inserted between "All" and "beds".

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Subsection (d)(2) has been revised to read:

- 2) If the nursing home provider fails to file its report for a State fiscal year on or before the due date of the report, there shall, unless waived by the Department for reasonable cause, be added to the license fee imposed in subsection (b) above a penalty fee equal to 25% of the license fee imposed for the year.

In subsection (d)(5), after the word "agent" in line two, insert "within three years after the end of the fiscal year in which the assessment/license fee was due".

In subsection (e)(5) all references to "license fee" have been changed to read "assessment/license fee".

Subsection (f)(1) has been revised to read:

- 1) Any nursing home provider that fails to pay the full amount of an installment when due, or fails to report a change in licensed beds approved by the Department of Public Health prior to the due date of the installment, shall be charged, unless waived by the Department for reasonable cause, a penalty equal to 5% of the amount of the installment not paid on or before the due date, plus 5% of the portion thereof remaining unpaid on the last day of each month thereafter, not to exceed 100% of the installment amount not paid on or before the due date.

Section 140.461

Subsections (f)(2)(B)(1), (ii) and (iii) have been revised to read:

- (i) In the case of clinics described in subsections (f)(1)(A) and (f)(1)(B) above, a pediatric or family practice residency program accredited by the American Accreditation Council for Graduate Medical Education or other published source of accrediting information.

- (ii) In the case of clinics described in subsection (f)(1)(C) above, an obstetrical residency program accredited by the American Accreditation Council for Graduate Medical Education or other published source of accrediting information with at least 130 full-time equivalent residents.

- (iii) In the case of clinics described in subsection (f)(1)(D) above, a pediatric or family practice residency program accredited by the American Accreditation Council for

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Graduate Medical Education or other published source of accrediting information with at least 130 full-time equivalent residents.

Subsection (f)(3)(B)(v) has been deleted in its entirety, and Subsections (f)(3)(B)(vi) and (vii) have been renumbered to (v) and (vi).

Subsection (f)(4) has been revised to read:

(4) Data Requirements

The Healthy Moms/Healthy Kids managed care clinics described in subsection (f)(1) above shall be required to submit patient level historical data to the Department, which may include, but shall not be limited to historical data on the use of the hospital emergency room department.

Subsections (f)(4)(A) and (B) have been deleted in their entirety.

Section 140.462

In subsection (d)(1), the words, "With respect to" have been underlined.

Section 140.523

Subsection (b) has been revised to read, "(b) ICF/MR Facilities (including ICF/DD and SNF/PED facilities)."

Subsection (b)(2) has been changed to read, "(2) There is no minimum occupancy level ICF/MR facilities must meet for receiving bed reserve payments."

Section 140.928

Subsection (a)(4) has been revised by the addition of a new (H) which reads:

(H) The client was randomly assigned pursuant to Section 140.928(a)(2)(A).

12) Have all the changes agreed upon by the agency and JC&R been made as indicated in the agreement letter issued by JC&R? Yes

13) Will these Amendments replace Emergency Amendments currently in effect? Yes

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14) Are there any Amendments pending on this Part? Yes

Sections Proposed Action Illinois Register Citation

140.3	Amendment	October 29, 1993 (17 Ill. Reg. 18768)
140.420	Amendment	September 24, 1993 (17 Ill. Reg. 15444)
140.421	Amendment	September 24, 1993 (17 Ill. Reg. 15444)
140.469	Amendment	November 5, 1993 (17 Ill. Reg. 19012)
140.643	Amendment	October 29, 1993 (17 Ill. Reg. 18768)
140.645	Amendment	October 29, 1993 (17 Ill. Reg. 18768)

15) Summary and Purpose of Amendments:

Sections 140.2 through 140.485 and Sections 140.920 through Table M

The Department of Public Aid has proposed extensive changes in its rules governing payment for services to pregnant women and children, to implement the Healthy Moms/Healthy Kids Program. Corresponding amendments were effective on October 1, 1993, through emergency rulemaking which was published on October 22, 1993 at 17 Ill. Reg. 18611.

It has become evident in recent years that because of limited access to health care, pregnant women and children often use emergency rooms to obtain non-emergency services, causing them to receive episodic care outside of an established relationship with a single provider or group practice. Department initiatives to increase access to care for all Medicaid covered persons, including recognition of Federally Qualified Health Centers and Medicaid Partnerships, have not fully resolved the problem. Through the work of task forces charged with exploring and developing all areas of a program to increase access to adequate health care services, the immediate need for readily accessible health care for pregnant women and children became apparent. The Department has moved expeditiously to develop the provisions of the Healthy Moms/Healthy Kids Program, and work with medical providers who will be affected.

The Healthy Moms/Healthy Kids Program is a primary health care program coupled with case management services for Medicaid enrolled pregnant women and children. The program is designed to ensure access, and increase access, to quality health care services statewide by linking pregnant women and children through age 20 with a primary care provider or a Health Maintenance Organization (HMO) who will be responsible for providing primary care and arranging, or in some areas of the state, authorizing specialty care. The program components are as follows:

- 1) Managed Care Component - The managed care component is in place for clients who reside in a zip code served by a local Public Aid office located in the city of Chicago. The managed care component requires all pregnant women and children who fall in certain categories of

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Medical Assistance to choose a Primary Care Provider (PCP) from the listing of approved provider types. Under the managed care component, the selected PCP is responsible for locating, coordinating and monitoring all health care and utilization of non-emergency services.

2) Case Management Component - The case management component is in place statewide. Under the case management component, pregnant women and children under the age of six will be provided with case management services by a community-based case management agency that will be responsible for assisting the client in accessing health care and support services necessary to comply with their physicians' recommendations.

3) Enhanced Reimbursement Component - The Healthy Moms/Healthy Kids Program is designed to increase provider participation through special incentives for providers. These include increased payment rates for selected services and expedited payment. To participate in the program, providers must meet specific participation requirements, and sign a Healthy Moms/Healthy Kids provider agreement, in addition to being enrolled as a Medicaid provider.

Sections 140.71 through 140.84

This rulemaking provides for extensive changes in the Department's rules governing the provider assessments and license fees for hospitals, nursing homes and providers of care to persons with developmental disabilities. These changes are required to update the rules for implementation of the provider assessments and license fees which took effect on July 1, 1993, in accordance with Public Act 88-88.

Section 140.71 has been revised to allow for either C-13 invoice voucher advance payments or expedited claims payments for government-owned facilities, subject to approval by the Director or designee. The substantive changes in the remaining proposed amendments are summarized below.

Section 140.80 - For the period of July 1, 1993, through June 30, 1994, hospital providers will be assessed 1.88 percent of their adjusted gross hospital revenue for the most recent calendar year ending before the beginning of that State fiscal year. Beginning July 1, 1994, through June 30, 1995, hospital providers will be assessed 1.88 percent of their adjusted gross hospital revenue for the most recent calendar year ending before the beginning of that State fiscal year, multiplied by the Provider's Savings Rate, in accordance with these proposed amendments.

The Department will notify hospital providers of the Provider's Savings Rate, by mailing a notice to each provider's last known address as reflected by the Department's records.

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The due date for fourth quarter assessments has been changed to May 31, in accordance with Public Act 88-88. Due dates for requests for delayed payments have been changed to September 10 for installments due on September 30 of the year, March 11 for installments due on March 31 of the year, and May 10 for installments due on May 31 of the year. Second quarter delayed payment requests will continue to be due on or before December 10 for installments due on December 31 of the year.

Rural hospitals, as described in these proposed amendments, are exempt from the assessment imposed under Section 140.80. In addition, a hospital organized under the University of Illinois Hospital Act will continue to be exempt from the assessment imposed under Section 140.80, and the Department is now authorized to enter into an interagency agreement with such a hospital to make intergovernmental transfer payments to the Department.

Revenue generated from hospital swing-beds, as described in these proposed amendments, is subject to the assessment imposed under Section 140.80.

Language has been added to subsection (d)(6) which limits the timeframe for auditing the provider's assessment to three years after the end of the fiscal year in which the assessment was due.

Section 140.82 - For the period of July 1, 1993, through June 30, 1995, providers of care to persons with developmental disabilities will be assessed six percent of their adjusted gross developmentally disabled care revenue for the prior State fiscal year. The adjusted gross revenue will be based upon the provider's annualized applicable State fiscal year revenue.

The due date for fourth quarter assessments has been changed to May 31, in accordance with Public Act 88-88. Due dates for requests for delayed payments have been changed to September 10 for installments due on September 30 of the year, March 11 for installments due on March 31 of the year, and May 10 for installments due on May 31 of the year. Second quarter delayed payment requests will continue to be due on or before December 10 for installments due on December 31 of the year.

Language has been added to subsection (d)(6) which limits the timeframe for auditing the provider's assessment to three years after the end of the fiscal year in which the assessment was due.

Section 140.84 - For the period of July 1, 1993, through June 30, 1995, a nursing home license fee is imposed upon each nursing home provider in an amount equal to \$1.50 for each licensed bed day for the calendar quarter in which the payment is due. All beds subject to licensure under the Nursing Home Care Act or the Hospital Licensing Act, with the exception of

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swing-beds, and sheltered care beds, as described in these proposed amendments, will be used to calculate the licensed bed days for each quarter.

In accordance with Public Act 88-88, nursing home providers are precluded from billing or passing on the license fee to any resident of a nursing home operated by the nursing home provider.

The due dates for nursing home license fees will be September 10, December 10, March 10, and June 10 of each applicable year. Due dates for requests for delayed payments will be August 20 for installments due on September 10 of the year, November 22 for installments due on December 10 of the year, February 18 for installments due on March 10 of the year, and May 20 for installments due on June 10 of the year.

Nursing home providers are required to file a report with the Department reflecting any changes in the number of licensed beds occurring during the reporting quarter. All changes in licensed beds will be effective upon approval of the change by the Illinois Department of Public Health, as described in these proposed amendments.

The procedure for partial year reporting and operating adjustments have been extensively revised in accordance with these proposed amendments.

Subsection (d)(2) has been revised to reflect the application of the 25% penalty for failure to file the annual report required under P.A. 87-861, as amended by P.A. 88-88.

Language has been added to subsection (d)(5) which limits the timeframe for auditing the provider's assessment to three years after the end of the fiscal year in which the assessment was due.

Subsection (f)(1) has been revised to reflect the application of the 5% penalty on a delinquent quarterly assessment amount as a result of the provider failing to report a change in licensed beds approved by the Department of Public Health.

Under Sections 140.80 through 140.84, payments for assessment/license fees are required on the designated due dates, regardless of changes in ownership or operators. Liability for the payment of the assessment/license fee amount, including past due assessments/license fees and any interest or penalties that may have accrued against the amount, will rest with the current facility owner/operator.

Section 140.523

These amendments establish a bed reserve program and reimbursement system which is specific for intermediate care facilities for persons with

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developmental disabilities (ICF/MR). These bed reserve changes for ICF/MR facilities were mandated by Public Act 88-247, to be effective by October 1, 1993. The intent of the legislation is to allow more liberal bed reserve periods for persons with disabilities, during which residential facilities can still qualify for bed reserve payments. This is necessary to ensure that individuals who consider the facilities in which they reside to be their homes, are not at risk of losing their residency status during extended hospitalizations and therapeutic leaves.

During hospitalizations, bed reserves are paid at a daily rate which is 100 percent of the current per diem rate for the first ten consecutive days, 75 percent of the current per diem for consecutive days 11 through 30, and 50 percent for consecutive days 31 through 45.

For therapeutic leaves from the facility, bed reserves are paid at a daily rate which is 100 percent of the current per diem rate for the first ten days per State fiscal year, and 75 percent for all subsequent days per fiscal year. According to a message of August 6, 1993 from the Governor, no limitation is to be placed on the number of paid bed reserve days for purposes of therapeutic leave. Bed reserve incentives are being provided to encourage families to spend time with family members who reside in ICF/MR facilities.

There is no minimum occupancy level an ICF/MR facility must maintain in order to qualify for bed reserve payments.

16) Information and questions regarding these Adopted Amendments shall be directed to:

Name: Joanne Jones
Address: Bureau of Rules and Regulations
Illinois Department of Public Aid
100 South Grand Avenue East, Third Floor
Springfield, Illinois 62762
Telephone: (217) 524-3215

The full text of the Adopted Amendments begins on the next page:

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NOTICE OF ADOPTED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER d: MEDICAL PROGRAMS

PART 140
MEDICAL PAYMENT

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140.1 Incorporation By Reference
140.2 Medical Assistance Programs
140.3 Covered Services Under The Medical Assistance Programs for AFDC, AFDC-MANG, AABD, AABD-MANG, RRP, Individuals Under Age 18 Not Eligible for AFDC, Pregnant Women Who Would Be Eligible if the Child Were Born and Pregnant Women and Children Under Age Eight Who Do Not Qualify As Mandatory Categorically Needy
140.4 Covered Medical Services Under AFDC-MANG for non-pregnant persons who are 18 years of age or older (Repealed)
140.5 Covered Medical Services Under GA
140.6 Medical Services Not Covered
140.7 Medical Assistance Provided to Individuals Under the Age of Eighteen Who Do Not Qualify for AFDC and Children Under Age Eight
140.8 Medical Assistance For Qualified Severely Impaired Individuals
140.9 Medical Assistance for a Pregnant Woman Who Would Not Be Categorically Eligible for AFDC/AFDC-MANG if the Child Were Already Born Or Who Do Not Qualify As Mandatory Categorically Needy
140.10 Medical Assistance Provided to Incarcerated Persons

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140.11 Enrollment Conditions for Medical Providers
140.12 Participation Requirements for Medical Providers
140.13 Definitions
140.14 Denial of Application to Participate in the Medical Assistance Program
140.15 Recovery of Money
140.16 Termination or Suspension of a Vendor's Eligibility to Participate in the Medical Assistance Program
140.17 Suspension of a Vendor's Eligibility to Participate in the Medical Assistance Program
140.18 Effect of Termination on Individuals Associated with Vendor
140.19 Application to Participate or for Reinstatement Subsequent to Termination, Suspension or Barring
140.20 Submittal of Claims
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140.22 Magnetic Tape Billings
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140.40 Prior Approval for Medical Services or Items
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140.42 Limitation on Prior Approval
140.43 Post Approval for items or Services When Prior Approval Cannot Be Obtained
140.71 Reimbursement for Medical Services Through the Use of a C-13
140.72 Invoice Voucher Advance Payment and Expedited Payments
140.73 Drug Manual (Recodified)
140.73 Drug Manual Updates (Recodified)

SUBPART C: PROVIDER ASSESSMENTS PARTICIPATION-FEE

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140.80 Hospital Provider Fund
140.82 Developmentally Disabled Care Provider Fund
140.84 Long Term Care Provider Fund
140.94 Medicaid Developmentally Disabled Provider Participation Fee Trust Fund/Medicaid Long Term Care Provider Participation Fee Trust Fund
140.95 Hospital Services Trust Fund
140.96 General Requirements (Recodified)
140.97 Special Requirements (Recodified)
140.98 Covered Hospital Services (Recodified)
140.99 Hospital Services Not Covered (Recodified)
140.100 Limitation On Hospital Services (Recodified)
140.101 Transplants (Recodified)
140.102 Heart Transplants (Recodified)
140.103 Liver Transplants (Recodified)
140.104 Bone Marrow Transplants (Recodified)
140.110 Disproportionate Share Hospital Adjustments (Recodified)
140.116 Payment for Inpatient Services for GA (Recodified)
140.117 Hospital Outpatient and Clinic Services (Recodified)
140.200 Payment for Hospital Services During Fiscal Year 1982 (Recodified)
140.201 Payment for Hospital Services After June 30, 1982 (Repealed)
140.202 Payment for Hospital Services During Fiscal Year 1983 (Recodified)
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140.300 Payment for Pre-operative Days and Services Which Can Be Performed
in an Outpatient Setting (Recodified)

140.350 Copayments (Recodified)

140.360 Payment Methodology (Recodified)

140.361 Non-Participating Hospitals (Recodified)

140.362 Pre July 1, 1989 Services (Recodified)

140.363 Post June 30, 1989 Services (Recodified)

140.364 Prepayment Review (Recodified)

140.365 Base Year Costs (Recodified)

140.366 Restructuring Adjustment (Recodified)

140.367 Inflation Adjustment (Recodified)

140.368 Volume Adjustment (Repealed)

140.369 Groupings (Recodified)

140.370 Rate Calculation (Recodified)

140.371 Payment (Recodified)

140.372 Review Procedure (Recodified)

140.373 Utilization (Repealed)

140.374 Alternatives (Recodified)

140.375 Exemptions (Recodified)

140.376 Utilization, Case-Mix and Discretionary Funds (Repealed)

140.390 Subacute Alcoholism and Substance Abuse Services (Recodified)

140.391 Definitions (Recodified)

140.392 Types of Subacute Alcoholism and Substance Abuse Services
(Recodified)

140.394 Payment for Subacute Alcoholism and Substance Abuse Services
(Recodified)

140.396 Rate Appeals for Subacute Alcoholism and Substance Abuse Services
(Recodified)

140.398 Hearings (Recodified)

SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

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140.400 Payment to Practitioners, Nurses and Laboratories

140.410 Physicians' Services

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140.425 Podiatry Services

140.426 Limitations on Podiatry Services

140.427 Requirement for Prescriptions and Dispensing of Pharmacy Items -
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140.428 Chiropractic Services

140.429 Limitations on Chiropractic Services (Repealed)

140.430 Independent Laboratory Services

140.431 Services Not Covered by Independent Laboratory

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140.441 Pharmacy Services Not Covered

140.442 Prior Approval of Prescriptions

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140.452 Mental Health Clinic Services

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140.454 Types of Mental Health Clinic Services

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140.457 Therapy Services

140.458 Prior Approval for Therapy Services

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140.460 Clinic Services

140.461 Clinic Participation, Data and Certification Requirements

140.462 Covered Services in Clinics

140.463 Clinic Service Payment

140.464 Healthy Moms/Healthy Kids Managed Care Clinics Psychiatric-Clinics
(Hospital-based)

140.465 Speech and Hearing Clinics (Repealed)

140.466 Rural Health Clinics

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AUTHORITY: Implementing Article III of the Illinois Health Finance Reform Act (Ill. Rev. Stat. 1991, ch. 111 1/2, par. 6503-1 et seq.) [20 ILCS 2215/Art. 3-4-et-seq.] and implementing and authorized by Articles III, IV, V, VI, VII and Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1991, ch. 23, pars. 3-1 et seq., 4-1 et seq., 5-1 et seq., 6-1 et seq., 7-1 et seq., and 12-13) [305 ILCS 5/Arts. 3, 4, 5, 6, 7, and 5/12-13]

SOURCE: Adopted at 3 Ill. Reg. 24, p. 166, effective June 10, 1979; rule repealed and new rule adopted at 6 Ill. Reg. 8374, effective July 6, 1982; emergency amendment at 6 Ill. Reg. 8508, effective July 6, 1982, for a maximum of 150 days; amended at 7 Ill. Reg. 681, effective December 30, 1982; amended at 7 Ill. Reg. 7956, effective July 1, 1983; amended at 7 Ill. Reg. 8308, effective July 1, 1983; amended at 7 Ill. Reg. 8271, effective July 5, 1983; emergency amendment at 7 Ill. Reg. 8354, effective July 5, 1983, for a maximum of 150 days; amended at 7 Ill. Reg. 8540, effective July 15, 1983; amended at 7 Ill. Reg. 9382, effective July 22, 1983; amended at 7 Ill. Reg. 12868, effective September 20, 1983; peremptory amendment at 7 Ill. Reg. 15047, effective October 31, 1983; amended at 7 Ill. Reg. 17358, effective December 21, 1983; amended at 8 Ill. Reg. 254, effective December 21, 1983; emergency amendment at 8 Ill. Reg. 580, effective January 1, 1984, for a maximum of 150 days; codified at 8 Ill. Reg. 2483; amended at 8 Ill. Reg. 3012, effective February 22, 1984; amended at 8 Ill. Reg. 5262, effective April 9, 1984; amended at 8 Ill. Reg. 6785, effective April 27, 1984; amended at 8 Ill. Reg. 6983, effective May 9, 1984; amended at 8 Ill. Reg. 7258, effective May 16, 1984; emergency amendment at 8 Ill. Reg. 7910, effective May 22, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 7910, effective June 1, 1984; amended at 8 Ill. Reg. 10032, effective June 18, 1984; emergency amendment at 8 Ill. Reg. 10062, effective June 20, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 13343, effective July 17, 1984; amended at 8 Ill. Reg. 13779, effective July 24, 1984; Sections 140.72 and 140.73 recodified to 89 Ill. Adm. Code 141 at 8 Ill. Reg. 16354; amended (by adding sections being codified with no substantive change) at 8 Ill. Reg. 17899; peremptory amendment at 8 Ill. Reg. 18151, effective September 18, 1984; amended at 8 Ill. Reg. 21629,

effective October 19, 1984; peremptory amendment at 8 Ill. Reg. 21677, effective October 24, 1984; amended at 8 Ill. Reg. 22097, effective October 29, 1984; peremptory amendment at 8 Ill. Reg. 22155, effective October 29, 1984; amended at 8 Ill. Reg. 23218, effective November 20, 1984; emergency amendment at 8 Ill. Reg. 23721, effective November 21, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 25067, effective December 19, 1984; emergency amendment at 9 Ill. Reg. 407, effective January 1, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 2697, effective February 22, 1985; amended at 9 Ill. Reg. 6235, effective April 19, 1985; amended at 9 Ill. Reg. 9564, effective June 5, 1985; effective May 28, 1985; amended at 9 Ill. Reg. 10025, effective June 26, 1985; emergency amendment at 9 Ill. Reg. 11403, effective June 27, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 11357, effective June 28, 1985; amended at 9 Ill. Reg. 12000, effective July 24, 1985; amended at 9 Ill. Reg. 12306, effective August 5, 1985; amended at 9 Ill. Reg. 13998, effective September 3, 1985; amended at 9 Ill. Reg. 14684, effective September 13, 1985; amended at 9 Ill. Reg. 15503, effective October 4, 1985; amended at 9 Ill. Reg. 16312, effective October 11, 1985; amended at 9 Ill. Reg. 19138, effective December 2, 1985; amended at 9 Ill. Reg. 19737, effective December 9, 1985; amended at 10 Ill. Reg. 238, effective December 27, 1985; emergency amendment at 10 Ill. Reg. 798, effective January 1, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 672, effective January 6, 1986; amended at 10 Ill. Reg. 1206, effective January 13, 1986; amended at 10 Ill. Reg. 3041, effective January 24, 1986; amended at 10 Ill. Reg. 6981, effective April 16, 1986; amended at 10 Ill. Reg. 7825, effective April 30, 1986; amended at 10 Ill. Reg. 8128, effective May 7, 1986; emergency amendment at 10 Ill. Reg. 8912, effective May 13, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 11440, effective June 20, 1986; amended at 10 Ill. Reg. 14714, effective August 27, 1986; amended at 10 Ill. Reg. 15211, effective September 12, 1986; emergency amendment at 10 Ill. Reg. 16729, effective September 18, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 18808, effective October 24, 1986; amended at 10 Ill. Reg. 19742, effective November 12, 1986; amended at 10 Ill. Reg. 21784, effective December 15, 1986; amended at 11 Ill. Reg. 698, effective December 19, 1986; amended at 11 Ill. Reg. 1418, effective December 31, 1986; amended at 11 Ill. Reg. 2323, effective January 16, 1987; amended at 11 Ill. Reg. 4002, effective February 25, 1987; Section 140.71 recodified to 89 Ill. Adm. Code 141 at 11 Ill. Reg. 4302; amended at 11 Ill. Reg. 4303, effective March 6, 1987; amended at 11 Ill. Reg. 7664, effective April 15, 1987; emergency amendment at 11 Ill. Reg. 9342, effective April 20, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 9169, effective April 28, 1987; amended at 11 Ill. Reg. 10903, effective June 1, 1987; amended at 11 Ill. Reg. 11528, effective June 22, 1987; amended at 11 Ill. Reg. 12011, effective June 30, 1987; amended at 11 Ill. Reg. 12290, effective July 6, 1987; amended at 11 Ill. Reg. 14048, effective August 14, 1987; amended at 11 Ill. Reg. 14771, effective August 25, 1987; amended at 11 Ill. Reg. 16758, effective September 28, 1987; amended at 11 Ill. Reg. 17295, effective September 30, 1987; amended at 11 Ill. Reg. 18696, effective October 27, 1987; amended at 11 Ill. Reg. 20909, effective December 14, 1987; amended at 12 Ill. Reg. 916, effective January 1, 1988;

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emergency amendment at 12 Ill. Reg. 1960, effective January 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 5427, effective March 15, 1988; amended at 12 Ill. Reg. 6246, effective March 16, 1988; amended at 12 Ill. Reg. 6728, effective March 22, 1988; Sections 140.900 thru 140.912 and 140.914 and 140.916 reclassified to 89 Ill. Reg. 6956; amended at 12 Ill. Reg. 6927, effective April 5, 1988; Sections 140.940 thru 140.972 reclassified to 89 Ill. Reg. 6956; amended at 12 Ill. Reg. 7401, effective April 21, 1988; amended at 12 Ill. Reg. 7695, effective April 21, 1988; amended at 12 Ill. Reg. 10497, effective June 3, 1988; amended at 12 Ill. Reg. 10717, effective June 14, 1988; emergency amendment at 12 Ill. Reg. 11868, effective July 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 12509, effective July 15, 1988; amended at 12 Ill. Reg. 14271, effective August 29, 1988; emergency amendment at 12 Ill. Reg. 16921, effective September 28, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 16738, effective October 5, 1988; amended at 12 Ill. Reg. 17879, effective October 24, 1988; amended at 12 Ill. Reg. 18198, effective November 4, 1988; amended at 12 Ill. Reg. 19396, effective November 6, 1988; amended at 12 Ill. Reg. 19734, effective November 15, 1988; amended at 13 Ill. Reg. 125, effective January 1, 1989; amended at 13 Ill. Reg. 2475, effective February 14, 1989; amended at 13 Ill. Reg. 3069, effective February 28, 1989; amended at 13 Ill. Reg. 3351, effective March 6, 1989; amended at 13 Ill. Reg. 3917, effective March 17, 1989; amended at 13 Ill. Reg. 5115, effective April 3, 1989; amended at 13 Ill. Reg. 5718, effective April 10, 1989; Sections 140.850 thru 140.896 reclassified to 89 Ill. Reg. 146.5 thru 146.225 at 13 Ill. Reg. 7040; amended at 13 Ill. Reg. 7025, effective April 24, 1989; amended at 13 Ill. Reg. 7786, effective May 20, 1989; Sections 140.94 thru 140.398 reclassified to 89 Ill. Reg. 148.10 thru 148.390 at 13 Ill. Reg. 9572; emergency amendment at 13 Ill. Reg. 10977, effective July 1, 1989, for a maximum of 150 days; emergency expired November 28, 1989; amended at 13 Ill. Reg. 11516, effective July 3, 1989; amended at 13 Ill. Reg. 12119, effective July 7, 1989; Section 140.110 reclassified to 89 Ill. Reg. 12119, 148.120 at 13 Ill. Reg. 12118; amended at 13 Ill. Reg. 12562, effective July 17, 1989; amended at 13 Ill. Reg. 14391, effective August 31, 1989; emergency amendment at 13 Ill. Reg. 15473, effective September 12, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 16992, effective October 16, 1989; amended at 14 Ill. Reg. 190, effective December 21, 1989; amended at 14 Ill. Reg. 2564, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 3241, effective February 14, 1990, for a maximum of 150 days; emergency expired July 14, 1990; amended at 14 Ill. Reg. 4543, effective March 12, 1990; emergency amendment at 14 Ill. Reg. 4577, effective March 6, 1990, for a maximum of 150 days; emergency expired August 3, 1990; emergency amendment at 14 Ill. Reg. 5575, effective April 1, 1990, for a maximum of 150 days; emergency expired August 29, 1990; emergency amendment at 14 Ill. Reg. 5865, effective April 3, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 7141, effective April 27, 1990; emergency amendment at 14 Ill. Reg. 7249, effective April 27, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 10062, effective June 12, 1990; amended at 14 Ill. Reg. 10409, effective June 19, 1990; emergency amendment at 14 Ill. Reg. 12082, effective July 5, 1990,

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for a maximum of 150 days; amended at 14 Ill. Reg. 13262, effective August 6, 1990; emergency amendment at 14 Ill. Reg. 14184, effective August 16, 1990, for a maximum of 150 days; emergency amendment at 14 Ill. Reg. 14570, effective August 22, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 14826, effective August 31, 1990; amended at 14 Ill. Reg. 15366, effective September 12, 1990; amended at 14 Ill. Reg. 15981, effective September 21, 1990; amended at 14 Ill. Reg. 17279, effective October 12, 1990; amended at 14 Ill. Reg. 18057, effective October 22, 1990; amended at 14 Ill. Reg. 18508, effective October 30, 1990; amended at 14 Ill. Reg. 18813, effective November 6, 1990; amended at 14 Ill. Reg. 20478, effective December 7, 1990; amended at 14 Ill. Reg. 20729, effective December 12, 1990; amended at 15 Ill. Reg. 298, effective December 28, 1990; emergency amendment at 15 Ill. Reg. 592, effective January 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 1051, effective January 18, 1991; Section 140.569 withdrawn at 15 Ill. Reg. 1174; amended at 15 Ill. Reg. 6220, effective April 18, 1991; amended at 15 Ill. Reg. 6534, effective April 30, 1991; amended at 15 Ill. Reg. 8264, effective May 23, 1991; amended at 15 Ill. Reg. 8972, effective June 17, 1991; amended at 15 Ill. Reg. 10114, effective June 21, 1991; amended at 15 Ill. Reg. 10468, effective July 1, 1991; amended at 15 Ill. Reg. 11176, effective August 1, 1991; emergency amendment at 15 Ill. Reg. 11515, effective July 25, 1991, for a maximum of 150 days; emergency expired December 22, 1991; emergency amendment at 15 Ill. Reg. 12919, effective August 15, 1991, for a maximum of 150 days; emergency expired January 12, 1992; emergency amendment at 15 Ill. Reg. 16366, effective October 22, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 17318, effective November 18, 1991; amended at 15 Ill. Reg. 17733, effective November 22, 1991; emergency amendment at 16 Ill. Reg. 300, effective December 20, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 174, effective December 24, 1991; amended at 16 Ill. Reg. 1877, effective January 24, 1992; amended at 16 Ill. Reg. 3552, effective February 28, 1992; amended at 16 Ill. Reg. 4006, effective March 6, 1992; amended at 16 Ill. Reg. 6408, effective March 20, 1992; amended at 16 Ill. Reg. 6849, effective April 7, 1992; amended at 16 Ill. Reg. 7017, effective April 17, 1992; amended at 16 Ill. Reg. 10050, effective June 5, 1992; amended at 16 Ill. Reg. 11174, effective June 26, 1992; expedited correction at 16 Ill. Reg. 11348, effective March 20, 1992; emergency amendment at 16 Ill. Reg. 11947, effective July 10, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 12186, effective July 24, 1992; emergency amendment at 16 Ill. Reg. 13337, effective August 14, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 15109, effective September 21, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 15561, effective September 30, 1992; amended at 16 Ill. Reg. 17302, effective November 2, 1992; emergency amendment at 16 Ill. Reg. 18097, effective November 17, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19146, effective December 1, 1992; amended at 16 Ill. Reg. 19879, effective December 7, 1992; amended at 17 Ill. Reg. 837, effective January 11, 1993; amended at 17 Ill. Reg. 1112, effective January 15, 1993; amended at 17 Ill. Reg. 2290, effective February 15, 1993; amended at 17 Ill. Reg. 2951, effective February 17, 1993; amended at 17 Ill. Reg. 3421, effective February 19, 1993; amended at 17 Ill. Reg. 6196, effective April 5, 1993; amended at 17

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Ill. Reg. 6839, effective April 21, 1993; amended at 17 Ill. Reg. 7004, effective May 17, 1993; expedited correction at 17 Ill. Reg. 7078, effective December 1, 1992; emergency amendment at 17 Ill. Reg. 11201, effective July 1, 1993, for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 15162, effective September 2, 1993, for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 18152, effective October 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 18571, effective October 8, 1993; emergency amendment at 17 Ill. Reg. 18611, effective October 1, 1993, for a maximum of 150 days; emergency amendment suspended effective October 12, 1993; amended at 17 Ill. Reg. 20999, effective November 24, 1993; emergency amendment repealed at 17 Ill. Reg. 22583, effective December 20, 1993; amended at 18 Ill. Reg. _____, effective February 28, 1994.

NOTE: CAPITALIZATION DENOTES STATUTORY LANGUAGE.

SUBPART A: GENERAL PROVISIONS

Section 140.2 Medical Assistance Program

a) Under the Medical Assistance Programs, the Department pays participating providers for necessary medical services, specified in Section 140.3 through 140.7 for:

- 1) persons eligible for financial assistance under the Department's Aid to the Aged, Blind or Disabled-State Supplemental Payment (AABD-SSP) and Aid to Families with Dependent Children (AFDC) programs (Medicaid - MAG);
- 2) persons who would be eligible for financial assistance but who have resources in excess of the Department's eligibility standards who have incurred medical expenses greater than the difference between their income and the Department's standards (Medicaid - MANG);
- 3) persons receiving financial assistance under the Department's General Assistance (GA) program, either State Transitional Assistance or State Family and Children Assistance (GA-Medical);
- 4) individuals under age 18 who do not qualify for AFDC/AFDC-MANG and infants under age one (1) year (see Section 140.7);
- 5) pregnant women who would not be eligible for AFDC/AFDC-MANG if the child were born and who do not qualify as mandatory categorically needy (see Section 140.9);

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Section 140.2(a) (continued)

- 6) persons who are eligible for Title IV-E adoption assistance/foster care assistance from another State and who are living in Illinois; and
 - 7) noncitizens who have an emergency medical condition (see 89 Ill. Adm. Code 120.310); however, payment is not included for care and services related to an organ transplant procedure.
- b) "Necessary medical care" is that which is generally recognized as standard medical care required because of disease, disability, infirmity or impairment.
- c) The Department may impose prior approval requirements, as specified by rule, to determine whether the medical care is necessary and eligible for payment from the Department in individual situations. Such requirements shall be based on recommendations of technical and professional staff and advisory committees.
- d) When recipients are entitled to Medicare benefits, the Department shall assume responsibility for their deductible and coinsurance obligations, unless the recipients have income and/or resources available to meet these needs. The total payment to a provider from both Medicare and the Department shall not exceed either the amount that Medicare determines to be a reasonable charge or the Department standard for the services provided, whichever is applicable.
- e) The Department shall pay for services and items not allowed by Medicare only if they are provided in accordance with Department policy for recipients not entitled to Medicare benefits.
- f) The Department may contract with qualified practitioners, hospitals and all other dispensers of medical services for the provision and reimbursement of any and all medical care or services as specified in the contract on a prepaid capitation basis (i.e., payment of a fixed amount per enrollee made in advance of the service); volume purchase basis (i.e., purchase of a volume of goods or services for a price specified in the contract); ambulatory visit basis (i.e., one comprehensive payment for each visit regardless of the services provided during that visit) or per discharge basis (i.e., one comprehensive payment per discharge regardless of the services provided during the stay). Such contracts shall be based either on formally solicited competitive bid proposals or individually negotiated rates with providers willing to enter into special contractual arrangements with the State.

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Section 140.2 (continued)

g). The Department may require that recipients of medical assistance under any of the Department's programs exercise their freedom of choice by choosing to receive medical care under the traditional fee for service system or through a prepaid capitation plan or under one of the other alternative contractual arrangements described in subsection (f) of this Section. The categories of recipients who may choose or be assigned to an alternative plan will be specified in the contract. Recipients required to make such a choice will be notified in writing by the Department. If a recipient does not choose to exercise his/her freedom of choice, the Department may assign that recipient to a prepaid plan. Under such a plan, recipients would obtain certain medical services or supplies from a single source or limited source. The Department will notify recipients in writing if they are assigned to a prepaid plan. Recipients enrolled in or assigned to a prepaid plan will receive written notification advising them of the services which they will receive from the plan. Covered services not provided by the plan will be reimbursed by the Department on a fee for service basis. Recipients will receive a medical eligibility card which will apply to such services.

h) The Department may enter into contracts for the provision of medical care on a prepaid capitation basis from a Health Maintenance Organization (HMO) whereby the recipient who chooses to receive medical care through an HMO must stay in the HMO for a certain period of time, not to exceed six months (the enrollment period). Upon written notice, the recipient may choose to disenroll from such an HMO at any time within the first month of each enrollment period. The Department will send the recipient a notice at least 30 days prior to the end of the enrollment period which gives the recipient a specified period of time in which to inform the Department if the recipient does not wish to re-enroll in the HMO for a new enrollment period. The recipient may then disenroll at the end of the enrollment period only if the recipient responds to the notice and indicates in writing a choice to disenroll. Failure to respond to the notice will result in automatic re-enrollment for a new enrollment period. Recipients shall also be allowed to disenroll at any time for cause.

i) The Department may enter into contracts for the provision of medical care on a prepaid capitation basis from a Health Maintenance Organization whereby the recipient who chooses to receive medical care through an HMO may choose to disenroll at any time, upon written notice.

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Section 140.2 (continued)

j) ~~The Department shall pay for services under the Healthy Moms/Healthy Kids Program, a primary health care program for pregnant women and children (see Subpart G).~~

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

SUBPART B: MEDICAL PROVIDER PARTICIPATION

Section 140.12 Participation Requirements for Medical Providers

The provider shall agree to:

a) Verify eligibility of recipients prior to providing each service; ~~by checking~~

1) ~~the-Medicaid-Cards; or~~

2) ~~the-Temporary-Medicaid-Card-which-a-recipient-may-present-prior-to-his-receipt-of-a-regular-Medicaid-Card~~

b) Allow recipients the choice of accepting or rejecting medical or surgical care or treatment;

c) Provide supplies and services in full compliance with all applicable provisions of State and federal laws and regulations pertaining to nondiscrimination and equal employment opportunity including but not limited to:

1) Full compliance with Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color or national origin;

2) Full compliance with Section 504 of the Rehabilitation Act of 1973 and 45 CFR 84, which prohibit discrimination on the basis of handicap; and

3) Without discrimination on the basis of religious belief, political affiliation, sex, age or disability;

d) Comply with the requirements of applicable Federal and State laws and not engage in practices prohibited by such laws;

e) Hold confidential, and use for authorized program purposes only, all Medical Assistance information regarding recipients;

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Section 140.12 (continued)

- f) Furnish to the Department, in the form and manner requested by it, any information it requests regarding payments for providing goods or services, or in connection with the rendering of goods or services or supplies to recipients by the provider, his agent, employer or employee;
- g) Make charges for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges and in the same quality and mode of delivery as are provided to the general public;
- h) Accept as payment in full the amounts established by the Department.
- 1) If a provider accepts an individual eligible for medical assistance from the Department as a Medicaid recipient, such provider shall not bill, demand or otherwise seek reimbursement from that individual or from a financially responsible relative or representative of the individual for any service for which reimbursement would have been available from the Department if the provider had timely and properly billed the Department. For purposes of this subsection, "accepts" shall be deemed to include:
- A) an affirmative representation to an individual that payment for services will be sought from the Department;
 - B) an individual presents the provider with his or her Medicaid card and the provider does not indicate that other payment arrangements will be necessary; or
 - C) billing the Department for the covered medical service provided an eligible individual.
- 2) If an eligible individual is entitled to medical assistance with respect to a service for which a third party is liable for payment, the provider furnishing the service may not seek to collect from the individual payment for that service if the total liability of the third party for that service is at least equal to the amount payable for that service by the Department, and
- i) Accept assignment of Medicare benefits for public aid recipients eligible for Medicare, when payment for services to such persons is sought from the Department, and

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Section 140.12 (continued)

- j) Complete a Healthy Moms/Healthy Kids Provider Agreement in order to participate in the Healthy Moms/Healthy Kids Program (see Section 140.924(a)(1)(D)).

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 140.40 Prior Approval for Medical Services or Items

- a) The Department may impose prior approval requirements as specified by rule, to determine the essentialness of medical care provided in individual situations. Such requirements shall be based on recommendations of technical and professional staff and advisory committees.
- b) In general, in order for prior approval to be granted, items and services must be:
- 1) non-experimental,
 - 2) appropriate to the client's needs,
 - 3) necessary to avoid institutional care, and
 - 4) medically necessary to preserve health, alleviate sickness, or correct a handicapping condition.
- c) Providers are responsible for requesting prior approval for medical services or items. Prior approval requests must show:
- 1) the case name,
 - 2) patient name,
 - 3) case identification number,
 - 4) recipient number,
 - 5) patient age, address, and whether or not the patient resides in a group care facility,
 - 6) identification of the practitioner prescribing or ordering the item or service,
 - 7) diagnosis,

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Section 140.40(c) (continued)

- 8) description of item or service,
- 9) treatment plan,
- 10) how long the service or item will be needed, and
- 11) purchase or rental cost.
- d) To the extent possible, the request should show how the item or service is expected to correct or help the condition, and why the requested treatment plan is better than any other plan commonly used to deal with similar diagnoses or conditions. Anything unique to the medical condition or living arrangement affecting the choice of a recommended treatment plan or item should be explained.
- e) A written notice of disposition of the request for prior approval will be sent to the client within the time limits prescribed below. If the notice of disposition is not sent within the applicable time limit, prior approval will be granted automatically. Oral notification only will be given when a request for medical transportation is approved.
- f) Certain services of providers, other than the Primary Care Provider, under the Healthy Moms/Healthy Kids Program require authorization by the Primary Care Provider (see Section 140.932).

(Source: Amended at 18 Ill. Reg. —, effective February 28, 1994)

Section 140.71 Reimbursement for Medical Services Through the Use of a C-13 Invoice Voucher Advance Payment and Expedited Payments

- a) C-13 Invoice Voucher Advance Payments
 - 1) The C-13 invoice voucher, when used as an advanced payment, is an exception to the regular reimbursement process. It may be issued only under extraordinary circumstances to qualified providers of medical assistance services. C-13 advance payments will be made only to a hospital organized under the University of Illinois Hospital Act, subject to approval by the Director, or to qualified providers who meet the following requirements:
 - A) are enrolled with the Department of Public Aid;
 - B) have experienced an emergency which necessitates C-13 advance payments. Emergency in this instance is defined as

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Section 140.71(a)(1) (continued)

- a circumstance under which withholding of the advance payment would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:
 - i) agency system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the provider's ability to provide further services to clients is severely impaired; or
 - ii) cash flow problems encountered by a provider or group of providers which are unrelated to Agency technical system problems. These situations include problems which are exclusively those of the providers or problems related to State cash flow which result in delayed payments and extensive financial problems to a provider, adversely impacting on the ability to promptly serve the clients;
- c) serve a significant number of clients under the medical assistance program. Significant in this instance means:
 - i) for long term care facilities, 80 percent or more of their residents must be eligible for public assistance;
 - ii) for long term care facilities enrolled in the Exceptional Care Program, with four (4) or more residents receiving exceptional care;
 - iii) for hospitals, they must qualify as a disproportionate share hospital;
 - iv) for practitioners and other medical providers, 50 percent or more of their patient revenue must be generated through Medicaid reimbursement;
 - v) for sole source pharmacies in a community which are not within a 25-mile radius of another pharmacy, the provisions of this Section may be waived;
 - vi) for government-owned facilities, this subsection (a)(1)(C) ~~Section-6~~ may be waived if the cash flow criteria under (a)(1)(B)(ii) is met; and

Section 140.71(a)(1)(C) (continued)

vii) for providers who have filed for Chapter 11 bankruptcy, ~~Section 6~~ this subsection (a)(1)(C) may be waived if the cash flow criteria under (a)(1)(B)(ii) is met;

D) sign an agreement with the Department which specifies the terms of advance payment and subsequent repayment. The agreement will contain the following provisions:

- i) specific reason(s) for advanced payments;
- ii) specific amount agreed to be advanced;
- iii) specific date to begin recoupment; and

iv) method of recoupment (percentage of payable amount of each Medicaid Management Information System voucher, specific amount per month, a warrant intercept, or a combination of the three recovery methods).

2) Determination of amount of payment to be issued shall be based on anticipated future payments as determined by the Department.

3) Approval process

A) In order to obtain C-13 advance payments, providers must submit their request in writing (telefax requests are acceptable) to the appropriate Bureau Chief within the Division of Medical Programs. The request must include:

- i) an explanation of the circumstances creating the need for the advance payments;
- ii) supportive documentation to substantiate the emergency nature of the request and risk of irreparable harm to the clients; and
- iii) specification of the amount of the advance required.

B) An agreement will be issued to the provider for all approved requests. The agreement must be signed by the administrator, owner, chief executive officer or other authorized representative and be received by the Department prior to release of the warrant.

Section 140.71(a)(3) (continued)

C) C-13 advance payments shall be authorized for the provider following approval by the Medicaid Administrator or designee. Once all requirements of this subsection (a)(3) are met, the Administrator will authorize payment within 7 days.

4) Recoupment

A) Health care entities other than individual practitioners shall be required to sign an agreement stating that, should the entity be sold, the new owners will be made aware of the liability and will assume responsibility for repaying the debt to the Department according to the original agreement.

B) All providers shall sign an agreement specifying the terms of recoupment. An agreed percentage of the total payment to the provider for services rendered shall be deducted from future payments until the debt is repaid. For providers who are properly certified, licensed or otherwise qualified under appropriate State and federal requirements, the recoupment period shall not exceed six (6) months from the month in which payment is authorized. For those providers enrolled but not in good standing (e.g., decertification termination hearing or other adverse action is pending), recoupment will be made from the next available payments owed the provider.

C) In the event that the provider fails to comply with the recoupment terms of the agreement, the remaining balance of any advance payment shall be immediately recouped from claims being processed by the Department. If such claims are insufficient for complete recovery, the remaining balance will become immediately due and payable by check to the Illinois Department of Public Aid. Failure by the provider to remit such check will result in the Agency pursuing other collection methods.

5) Prior Agreements

The terms of any agreement signed between the provider and the Department prior to the adoption of this rule will remain in effect, notwithstanding the provisions of this rule.

b) Expedited Claims Payments

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Section 140.71(b) (continued)

- 1) Expedited claims payments are issued through the regular MMIS payment process and represent an acceleration of the regular payment schedule. They may be issued only under extraordinary circumstances to qualified providers of medical assistance services. Reimbursement through the expedited process will be made only to a hospital organized under the University of Illinois Hospital Act, subject to approval by the Director, or to qualified providers who meet the following requirements:
 - A) are enrolled with the Department of Public Aid;
 - B) have experienced an emergency which necessitate expedited payments. Emergency in this instance is defined as a circumstance under which withholding of the expedited payment would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:
 - i) agency system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the provider's ability to provide further services to the clients is severely impaired;
 - ii) cash flow problems encountered by a provider or group of providers which are unrelated to Agency technical system problems. These situations include problems which are exclusively those of the providers (i.e., provider billing system problems) or problems related to State cash flow which result in delayed payments and extensive financial problems to a provider adversely impacting on the ability to serve the clients;
 - C) serve a significant number of clients under the Medical Assistance Program. Significant in this instance means:
 - i) for long term care facilities, 80 percent or more of their residents must be eligible for public assistance;
 - ii) for hospitals, they must qualify as a disproportionate share hospital;
 - iii) for practitioners and other medical providers, 50 percent or more of their patient revenue be generated through Medicaid reimbursement;

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Section 140.71(b)(1)(C) (continued)

- iv) for sole source pharmacies in a community which are not within a 25-mile radius of another pharmacy, the provisions of this Section may be waived;
 - v) for government-owned facilities, this subsection (b)(1)(C) Section-6 may be waived if the cash flow criteria under (a)(1)(B)(ii) ~~is~~ are met; and
 - vi) for providers who have filed for Chapter 11 bankruptcy, subsection (b)(1)(C) Section-6 may be waived if the cash flow criteria under subsection (a)(1)(B)(ii) ~~is~~ are met.
- 2) Reimbursement will be based upon the amount of claims determined payable and be made for a period specified by the Department.
 - 3) Approval process
 - A) In order to qualify for expedited payments, providers must submit their request in writing (telefax requests are acceptable) to the appropriate Bureau Chief within the Division of Medical Programs. The request must include:
 - i) an explanation of the need for the expedited payments; and
 - ii) supportive documentation to substantiate the emergency nature of the request.
 - B) Expedited payments shall be authorized for the provider following approval by the Medicaid Administrator or designee.
 - C) The Department will periodically review the need for any continued expedited payments.
 - 4) Prior Agreements

The terms of any agreement signed between the provider and the Department prior to the adoption of this rule will remain in effect, notwithstanding the provisions of this rule.

(Source: Amended at 18 Ill. Reg. —, effective February 28, 1994)

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SUBPART C: PROVIDER ASSESSMENTS PARTICIPATION FEES

Section 140.80 Hospital Provider Fund

a) Purpose and Contents.

- 1) The Hospital Provider Fund ("Fund") was created in the State Treasury upon enactment of Public Act 87-861 and Public Act 88-88. Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used to replace any funds appropriated to the Medicaid program by the General Assembly.
- 2) The Fund is created for the purpose of receiving and disbursing monies in accordance with this Section and Public Act 87-861, as amended by Public Act 88-88.
- 3) The Fund shall consist of:
 - A) All monies collected or received by the Department under subsection ~~subsections~~ (b) below;
 - B) All federal matching funds received by the Department as a result of expenditures made by the Department that are attributable to monies deposited in the Fund;
 - C) Any interest or penalty levied in conjunction with the administration of the Fund;
 - D) All other monies received for the Fund from any other source, including interest earned thereon; and
 - E) All monies transferred from the Hospital Services Trust Fund-i and
 - F) All monies transferred from the Tobacco Products Tax Act.
- b) Provider Assessments

Beginning on July 1, 1992 1993, and ending on June 30, 1994, an assessment is imposed upon each hospital provider ~~for the State fiscal year beginning on July 1, 1992 and ending on June 30, 1993~~ in an amount equal to 2.5% 1.88% of the provider's adjusted gross hospital revenue, as described in subsection (1)(1) of this Section, for the most recent calendar year ending before the beginning of that State fiscal year. An assessment is imposed upon each hospital provider for the fiscal year beginning on July 1, 1994, and ending on June 30, 1995, in an amount equal to the provider's adjusted gross hospital revenue, as described in subsection (1)(1) of this Section,

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Section 140.80(b) (continued)

- for the most recent calendar year ending before the beginning of that State fiscal year multiplied by the Provider's Savings Rate, as described in subsection (1)(10) of this Section. The Department reserves the right to audit the reported data. The Department shall notify hospital providers of the Provider's Savings Rate by mailing a notice to each provider's last known address as reflected by the records of the Department. ~~Adjusted gross hospital revenue will be based upon the provider's annualized calendar year 1991 revenue reported on the Hospital Provider tax form to be filed by a date designated by the Department. The Department reserves the right to audit the reported data.~~
- c) Payment of Assessment Due.
 - 1) The assessments ~~described~~ imposed in subsection (b) above shall be due and payable in quarterly installments, each equalling one-fourth of the assessment for the year, on September 30, December 31, March 31, and June 30 May 31 of the year. Assessment payments postmarked on the due date will be considered as paid on time.
 - 2) All payments received by the Department shall be credited first to unpaid installment amounts (rather than to penalty or interest), beginning with the most delinquent installments.
 - d) Reporting Requirements, Penalty, and Maintenance of Records
 - 1) After December 31 of each year, and on or before March 31 of the succeeding year, every hospital provider subject to an assessment under subsection (b) above shall file a report with the Department. The report shall be on a form prepared by the Department. The report shall include the adjusted gross hospital revenue from the calendar year just ended and shall be utilized by the Department to calculate the assessment for the State fiscal year commencing on the next July 1 ~~except that the report for the State fiscal year commencing July 1, 1992 and the report of revenue for calendar year 1991 shall be filed on or before September 30, 1992.~~ If a hospital provider conducts, operates, or maintains more than one hospital licensed by the Illinois Department of Public Health, a separate report shall be filed for each hospital. In the case of a hospital provider existing as a corporation or legal entity other than an individual, the report filed by it shall be signed by its president, vice-president, secretary, or treasurer or by its properly authorized agent.

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Section 140.80(d) (continued)

- 2) If the hospital provider fails to file its report for a State fiscal year on or before the due date of the report, there shall, unless waived by the Department for reasonable cause, be added to the assessment imposed in subsection (b) above a penalty assessment equal to 25% of the assessment imposed for the year.
- 3) Every hospital provider subject to an assessment under subsection (b) above shall keep records and books that will permit the determination of adjusted gross hospital revenue on a calendar year basis. All such books and records shall be maintained for a minimum of three (3) years following the filing date of the assessment report and shall, at all times during business hours of the day, be subject to inspection by the Department or its duly authorized agents and employees.
- 4) Amended Assessment Reports. With the exception of amended assessment reports filed in accordance with subsections (d)(5) or (6) below, an amended assessment report must be filed within 30 calendar days of the original report due date. The amended report must be accompanied by a letter identifying the changes and the justification for the amended report. The provider will be advised of any adjustments to the original annual assessment amount through a written notification from the Department. Penalties may be applied to the amount underpaid due to a filing error.
- 5) Submission of Financial Audit Statements. All hospital providers are required to submit a copy of all financial statements audited by an external, independent auditor, to the Department within thirty-(30) days of the close of such externally performed financial audits. If the hospital's year end does not coincide with the December 31st ending date for the tax assessment report, the hospital must submit all financial audits covering the tax assessment report period. An amended tax assessment report must accompany such external financial audit statements if the data submitted on the initial tax assessment report changes based upon the findings of such external financial audits and as indicated in the audited external financial statements. Penalties may be applied to the amount underpaid due to a filing error.
- 6) Reconsideration of Adjusted Tax. If the Department, through an audit conducted by the Department or its agent within three years after the end of the fiscal year in which the assessment was due, changes the tax assessment liability of a hospital

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Section 140.80(d)(6) (continued)

- provider, the hospital provider may request a review or reconsideration of the adjusted tax assessment within thirty (30) days of the Department's notification of the change in tax assessment liability. Requests for reconsideration of the tax assessment adjustment shall not be considered if such requests are not postmarked on or before the end of the thirty-(30) day review period. Penalties may be applied to the amount underpaid due to a filing error.
- e) Procedure for Partial Year Reporting/Operating Adjustments
 - 1) Cessation of business during the fiscal year in which the tax assessment is being paid. If a hospital provider ceases to conduct, operate, or maintain a hospital in respect for which the person is subject to assessment under subsection (b) above, the assessment for the State fiscal year in which the cessation occurs shall be adjusted by multiplying the assessment computed under subsection (d) by a fraction, the numerator of which is the number of days in the year during which the provider conducts, operates, or maintains the hospital and the denominator of which is 365. The person shall file a final, amended report with the Department not more than 90 calendar days after the cessation, reflecting the adjustment and shall pay with the final return the assessment for the year as so adjusted, to the extent not previously paid.
 - 2) Commencing of business during the fiscal year in which the tax assessment is being paid. A hospital provider who commences conducting, operating, or maintaining a hospital for which the person is subject to assessment under subsection (b) above, shall file an initial report for the State fiscal year in which the commencement occurs within 90 calendar days thereafter and shall pay the assessment under subsection (d) above as computed by the Department in equal installments on the due date of the initial assessment determination and on the regular installment due dates for the State fiscal year occurring after the due date of the initial assessment determination. In determining the annual assessment amount for the provider the Department shall develop hypothetical annualized revenue projections based upon geographic location, facility size and patient case mix. The assessment determination made by the Department is final.
 - 3) Partial Calendar Year Operation Adjustment. For a hospital provider that did not conduct, operate, or maintain a hospital throughout the entire calendar year reporting period, the

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Section 140.80(e)(3) (continued)

assessment for the following State fiscal year shall be annualized based on the provider's actual revenues for the portion of the reporting period the hospital was operational (dividing adjusted gross hospital revenue by the number of days the hospital was in operation and then multiplying the amount by 365). Revenues realized by a prior provider from the same hospital during the calendar year shall be used in the annualization equation, if available.

- 4) Change in Ownership and/or Operators. The full quarterly assessment must be paid on the designated due dates regardless of changes in ownership or operators. Liability for the payment of the assessment amount (including past due assessments and any interest or penalties that may have accrued against the amount) rests on the hospital provider currently operating or maintaining the hospital regardless if these amounts were incurred by the current owner or were incurred by previous owners. Collection of delinquent assessment fees from previous providers will be made against the current provider. Failure of the current provider to pay any outstanding assessment liabilities incurred by previous providers shall result in the application of penalties described in subsection (f)(1) of this Section.

f) Penalties

- 1) Any hospital that fails to pay the full amount of an installment when due shall be charged, unless waived by the Department for reasonable cause, a penalty equal to 5% of the amount of the installment not paid on or before the due date, plus 5% of the portion thereof remaining unpaid on the last day of each month thereafter, not to exceed 100% of the installment amount not paid on or before the due date.
- 2) Within forty-five (45) days from the due date, the Department may begin recovery actions against delinquent hospitals participating in the Medicaid Program. Payments may be withheld from the hospital until the entire provider-fee assessment, including any penalties, is satisfied or until a reasonable repayment schedule has been approved by the Department. If a reasonable agreement cannot be reached or if a hospital fails to comply with an agreement the Department reserves the right to recover any outstanding provider assessment, interest and penalty by recouping the amount or a portion thereof from the hospital's future payments from the Department. The provider may appeal this recoupment in accordance with Department rules

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Section 140.80(f)(2) (continued)

contained in 89 Ill. Adm. Code 104. The Department has the right to continue recoupment during the appeal process. Penalties pursuant to subsection (f)(1) above will continue to accrue during the recoupment process. Recoupment proceedings against the same hospital two times in a fiscal year may be cause for termination from the Program. Failure by the Department to initiate recoupment activities within 45 days shall not reduce the provider's liabilities nor shall it preclude the Department from taking action at a later date.

- 3) If the hospital does not participate in the Medicaid Program, or is no longer doing business with the Department, or the Department cannot recover the full amount due through the claims processing system, within three months of the fee due date, the Department may begin legal action to recover the monies, including penalties and interest owed, plus court costs.

g) Delayed Payment - Groups of Hospitals

The Director may establish delayed payment of fees assessments and/or waive the payment of interest and penalties for groups of hospitals such as disproportionate share hospitals or all other hospitals when:

- 1) the State delays payments to hospitals due to problems related to state cash flow, or
- 2) a cash flow bond pool's, or any other group financing plans', requests from providers for loans are in excess of its scheduled proceeds such that a significant number of hospitals will be unable to obtain a loan to pay the fee assessment.

h) Delayed Payment - Individual Hospitals

In addition to the provisions of subsection (g) above, the Director may delay fee assessments for individual hospitals that are unable to make timely payments under this Section due to financial difficulties. No delayed payment arrangements shall extend beyond the last business day of the calendar quarter following the quarter in which the fee assessment was to have been received by the Department as described in subsection (c) above.

- 1) Criteria. Delayed payment provisions may be instituted only under extraordinary circumstances. Delayed payment provisions may be made only to qualified hospitals who meet all of the following requirements:

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Section 140.80(h)(1) (continued)

- A) the provider has experienced an emergency which necessitates institution of delayed payment provisions. Emergency in this instance is defined as a circumstance under which institution of the payment and penalty provisions described in subsections (c)(1), (c)(2), (f)(1) and (f)(2) above would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:
- i) Department system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the provider's ability to provide further services to clients is severely impaired;
 - ii) cash flow problems encountered by a provider which are unrelated to Department technical system problems and which result in extensive financial problems to a facility, adversely impacting on its ability to serve its clients.
- B) the provider serves a significant number of clients under the medical assistance program. "Significant" in this instance means:
- i) a hospital that serves a significant number of clients under the medical assistance program; significant in this instance means that the hospital qualifies as a disproportionate share hospital under 89 Ill. Adm. Code 148.120(a)(1) through 148.120(a)(5); or qualifies as a Medicare DSH hospital under the current federal guidelines.
 - ii) a government-owned facility, which meets the cash flow criterion under subsection (h)(1)(A)(ii) above.
 - iii) a hospital which has filed for Chapter 11 bankruptcy, which meets the cash flow criteria under subsection (h)(1)(A)(ii) above.
- C) the provider must file a delay of payment request as defined under subsection (h)(3)(A) below, and the request must include a Cash Position Statement which is based upon current assets, current liabilities and other data for a date which is less than ~~sixty~~ 60 days prior to the date of filing. Any liabilities payable to owners or related

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Section 140.80(h)(1)(C) (continued)

- parties must not be reported as current liabilities on the Cash Position Statement. A deferral of assessment payments will be denied if any of the following criteria are met:
- i) the ratio of current assets divided by current liabilities is greater than 2.0.
 - ii) cash, short term investments and long term investments equal or exceed the total of accrued wages payable and the assessment payment. Long term investments which are unavailable for expenditure for current operations due to donor restrictions or contractual requirements will not be used in this calculation.
- D) the provider must show evidence of denial of an application to borrow ~~provider-participation-fee assessment~~ funds through a cash flow bond pool or financial institutions such as a commercial bank. The denial must be 90 days old or less.
- E) the provider must sign an agreement with the Department which specifies the terms and conditions of the delayed payment provisions. The agreement shall contain the following provisions:
- i) specific reason(s) for institution of the delayed payment provisions;
 - ii) specific dates on which payments must be received and the amount of payment which must be received on each specific date described;
 - iii) the interest or a statement of interest waiver as described in subsection (h)(5) below that shall be due from the provider as a result of institution of the delayed payment provisions;
 - iv) a certification stating that, should the entity be sold, the new owners will be made aware of the liability and any agreement selling the entity will include provisions that the new owners will assume responsibility for repaying the debt to the Department according to the original agreement; and
 - v) a certification stating that all information submitted to the Department in support of the delayed payment

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Section 140.80(h)(1)(E)(v) (continued)

request is true and accurate to the best of the signator's knowledge.

vi) such other terms and conditions that may be required by the Department.

2) A hospital which does not meet the above criteria may request a delayed payment schedule and/or the waiver of interest and penalties. The Director may approve the request, notwithstanding the hospital not meeting the above criteria, upon a sufficient showing of financial difficulties and good cause by the hospital. If the request for a delayed payment schedule and/or waiver of interest and penalties is approved, all other conditions of this subsection (h) shall apply.

3) Approval Process.

A) In order to receive consideration for delayed payment provisions, providers must submit their request in writing (telefax requests are acceptable) to the Bureau of Program and Reimbursement Analysis. The request must be received as follows: delayed payment requests for installments due on September 30 of the year must be received on or before September 15 of the year; delayed payment requests for installments due on December 31 of the year must be received on or before December 10 of the year; delayed payment requests for installments due on March 31 of the year must be received on or before March 5 of the year; and delayed payment requests for installments due on June 30 of the year must be received on or before May 10 of the year. Requests must be complete and contain all required information before they are considered to have met the time requirements for filing a delayed payment request. All telefax requests must be followed up with original written requests, postmarked no later than the date of the telefax. The request must include:

- i) an explanation of the circumstances creating the need for the delayed payment provisions;
- ii) supportive documentation to substantiate the emergency nature of the request including a cash position statement as defined in subsection (h)(1)(C) of this Section, a denial of application to borrow the assessment as defined in subsection (h)(1)(D) of this Section and an explanation of the risk of irreparable harm to the clients; and

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Section 140.80(h)(3)(A) (continued)

iii) specification of the specific arrangements requested by the provider.

B) The hospital shall be notified by the Department, in writing prior to the assessment due date, of the Department's decision with regard to the request for institution of delayed payment provisions. An agreement shall be issued to the provider for all approved requests. The agreement must be signed by the administrator, owner, chief executive officer or other authorized representative and be received by the Department prior to the first scheduled payment date listed in such agreement.

4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) of this Section may be waived upon approval of the provider's request for institution of delayed payment provisions. In the event a provider's request for institution of delayed payment provisions is approved and the Department has received the signed agreement in accordance with subsection (h)(3)(B) above, such penalties shall be permanently waived for the subject quarter unless the provider fails to meet all of the terms and conditions of the agreement. In the event the provider fails to meet all of the terms and conditions of the agreement, the agreement shall be considered null and void and such penalties shall be fully reinstated.

5) Interest. The delayed payments shall include interest at a rate not to exceed the State of Illinois borrowing rate. The applicable interest rate shall be identified in the agreement described in subsection (h)(1)(E) above. The interest may be waived by the Director if the facility's current ratio, as described in subsection (h)(1)(C) above is 1.5 or less and the hospital meets the criteria in subsections (h)(1)(A) and (B) above. Any such waivers granted shall be expressly identified in the agreement described in subsection (h)(1)(E) above.

6) Subsequent Delayed Payment Arrangements. Once a provider has requested and received approval for delayed payment arrangements, the provider shall not receive approval for subsequent delayed payment arrangements until such time as the terms and conditions of any current delayed payment agreement have been satisfied or unless the provider is in full compliance with the terms of the current delayed payment agreement. The waiver of penalties described in subsection (h)(4) above shall not apply to a provider that has not satisfied the terms and conditions of any current delayed payment agreement.

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Section 140.80 (continued)

i) Administration and Enforcement Provisions

Pursuant to Section 5A-7 of P.A. 86-861, to the extent practicable, the Department shall administer and enforce P.A. 86-861 and by P.A. 88-88, and collect the assessments, interest, and penalty assessments imposed under the law, using procedures employed in its administration of this Code generally and, as it deems appropriate, in a manner similar to that in which the Department of Revenue administers and collects the retailers' occupation tax under the Retailers' Occupation Tax Act ("ROTA").

j) Exemptions

1) A rural hospital, as defined in subsection (1)(11) below, shall be exempt from the assessment imposed under subsection (b), unless the exemption is adjudged to be unconstitutional or otherwise invalid, in which case the provider shall pay the assessment imposed under subsection (b) above.

2) A hospital provider which is a county with a population of more than 3,000,000 that makes intergovernmental transfer payments as provided in Section 15-3 of P.A. 87-861, P.A. 88-85 and P.A. 88-88, shall be exempt from the assessment imposed by subsection (b) above, unless the exemption is adjudged to be unconstitutional or otherwise invalid, in which case the hospital shall pay the assessment imposed by subsection (b) above for all assessment periods beginning on or after July 1, 1992, and the assessment so paid shall be creditable against the intergovernmental transfer payments.

3) The Department is authorized to enter into an interagency agreement with a hospital organized under the University of Illinois Hospital Act and exempt from the assessment imposed under subsection (b) of this Section, to make intergovernmental transfer payments to the Department. These payments shall be deposited into the General Revenue Fund, A sole community hospital provider as defined in 89-III-Adm-Code-149.125(b) as in effect on July 1, 1992, whether public or private and whether assessments imposed by subsection (b) above shall be exempt from the exemption is adjudged to be unconstitutional or otherwise invalid, in which case the provider shall pay the assessments imposed by subsection (b) above. For the purpose of determining those hospitals that shall be exempt from the assessments imposed by subsection (b) above, the sole community hospital provider designation for FY 1993 (July 1, 1992 through June 30,

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Section 140.80(j)(3) (continued)

1993) will be effective on July 1, 1992 and shall apply to the period of July 1, 1992 through June 30, 1993.

4) The Department is also authorized to enter into agreements with publicly owned or operated hospitals not described in subsections (j)(1) through (j)(3) above to make intergovernmental transfer payments to the Department. These payments shall be deposited into the Hospital Provider Fund.

k) Nothing in P.A. 88-88 shall be construed to prevent the Department from collecting all amounts due under this Section pursuant to an assessment imposed before the effective date of P.A. 88-88.

l) Definitions.

As used in this Section, unless the context requires otherwise:

1) "Adjusted gross hospital revenue" means the hospital's provider's total gross patient charges revenue derived or related to patient care, less Medicare contractual allowances, bed debts, charity care, and discounts on patients' accounts, but does not include gross patient revenue (and the portion of any Medicare contractual allowance or discount-related thereto) from skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act. Revenue generated from swing beds, as described in subsection (1)(12) below, is considered to be part of the provider's gross hospital revenue. Revenue not related to patient care, such as, investment income, gift shop, cafeteria, or parking lot revenue is not considered as patient revenue. Adjusted gross hospital revenue must be reported on an accrual basis for the tax assessment reporting period. All patient revenue accrued during the tax assessment reporting period must be included even though reimbursement may occur after the tax assessment reporting period. Patient revenue must be reported on a basis that is consistent with methods used on the hospital's last two (2) cost reports.

2) "Cigarette Tax Contribution" is the sum of the total amount deposited in the Hospital Provider Fund in State fiscal year 1994 pursuant to Section 2(a) of the Cigarette Tax Act, plus the total amount deposited in the Hospital Provider Fund in State fiscal year 1994 pursuant to Section 5A-3(c) of Public Act 88-88.

2) "Gross Patient Allowance" means the difference between charges at established rates and the amount estimated to be paid by third-

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Section 140.80(1)(2) (continued)

party-payers or patients, as appropriate, pursuant to agreements/contracts with the hospital; court-ordered policy discounts provided to employees, medical staff and clergy; and charity care, but "contractual allowances" does not mean deductions if applicable to the skilled nursing facility or intermediate care facility revenue or any provider participation fees/taxes paid to the Illinois Department of Public Aid.

3) "Department" means the Illinois Department of Public Aid.

4) "Fund" means the Hospital Provider Fund.

5) "Hospital" means an institution, place, building, or agency located in this State that is subject to licensure by the Illinois Department of Public Health under the Hospital Licensing Act, whether public or private and whether organized for profit or not-for-profit.

6) "Hospital provider" means a person licensed by the Department of Public Health to conduct, operate, or maintain a hospital, regardless of whether the person is a Medicaid provider. For purposes of this definition, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.

7) "Intergovernmental transfer payment" means the payments established under Section 15-3 of P.A. 87-861, P.A. 88-85 and P.A. 88-88, and includes without limitation payments payable under that Section for July, August and September of 1992.

8) "Maximum Section 5A-2 Contribution" is the total amount of tax imposed by Section 5A-2 of Public Act 88-88 in State fiscal year 1994 on providers subject to the assessment imposed by subsection (b) above; multiplied by a fraction the numerator of which is adjusted gross hospital revenues reported to the Department by providers subject to the assessment imposed by subsection (b) for State fiscal year 1994 and the denominator of which is adjusted gross hospital revenues reported to the Department by providers subject to the assessment imposed by subsection (b) for State fiscal year 1993. "State community hospital provider" means a Medicaid-eligible community provider.

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Section 140.80(1)(8) (continued)

defined in 89 Ill. Adm. Code 149.125(b) whether public or private and whether organized for profit or not-for-profit.

9) "Medicare Contractual Allowance" means the difference between charges at established rates and the amount estimated to be paid by Medicare, as appropriate, pursuant to agreements between the hospital and the Health Care Financing Administration.

10) "Provider's Savings Rate" is 1.88% multiplied by a fraction, the numerator of which is the Maximum Section 5A-2 Contribution minus the Cigarette Tax Contribution, and the denominator of which is the Maximum Section 5A-2 Contribution.

11) "Rural hospital" means a hospital that is either located outside a metropolitan statistical area, or is located 15 miles or less from a county that is outside a metropolitan statistical area and that is licensed to perform medical/surgical or obstetrical services and has a combined approved total bed capacity of 75 or fewer beds in these two service categories as of the effective date of P.A. 88-88 (July 14, 1993), as determined by the Illinois Department of Public Health. The Illinois Department of Public Health must have been notified in writing of any changes to a facility's bed count on or before the effective date of P.A. 88-88 (July 14, 1993). Appeals of the geographic designation of a hospital provider shall be in accordance with 89 Ill. Adm. Code 148.310(m).

12) "Swing beds" means those beds for which a hospital provider has been granted an approval from the federal Health Care Financing Administration to provide post-hospital extended care services (42 CFR 409.30, October 1, 1991) and be reimbursed as a swing-bed hospital (42 CFR 413.114, October 1, 1991).

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 140.82 Developmentally Disabled Care Provider Fund

a) Purpose and Contents

1) The Developmentally Disabled Care Provider Fund was created in the State Treasury upon enactment of Public Act 87-861 and Public Act 88-88. Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used to replace any funds appropriated to the Medicaid program by the General Assembly.

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Section 140.82(1) (continued)

- 2) The Fund is created for the purpose of receiving and disbursing monies in accordance with this Section, and Public Act 87-861 and Public Act 88-88.
- 3) The Fund shall consist of:
 - A) All monies collected or received by the Department under subsection ~~subsections~~ (b) below;
 - B) All federal matching funds received by the Department as a result of expenditures made by the Department that are attributable to monies deposited in the Fund;
 - C) Any interest or penalty levied in conjunction with the administration of the Fund; and
 - D) All other monies received for the Fund from any other source, including interest earned thereon; and
 - E) All monies transferred from the Medicaid Developmentally Disabled Provider Participation Fee Trust Fund.

b) Provider Assessments

Beginning on July 1, 1992 1993, an assessment is imposed upon each developmentally disabled care provider for the State fiscal year beginning on July 1, 1992 1993, and ending on June 30, 1993 1993, in an amount equal to 12% six percent of its adjusted gross developmentally disabled care revenue for the prior State fiscal year. Adjusted gross developmentally disabled care revenue for the fiscal year beginning on July 1, 1993, will be based upon the provider's annualized State fiscal year 1993 FY-92 revenue. Adjusted gross developmentally disabled care revenue for the fiscal year beginning on July 1, 1994, will be based upon the provider's annualized State fiscal year 1994 revenue. The revenue for each year will be reported on the Developmentally Disabled Care Provider Tax form to be filed by a date designated by the Department. The Department reserves the right to audit the reported data.

c) Payment of Assessment Due

- 1) The assessment described in subsection (b) above shall be due and payable in quarterly installments, each equalling one-fourth of the assessment for the year, on September 30, December 31, March 31, and June-30 May 31 of the year. Assessment payments postmarked on the due date will be considered paid on time.

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Section 140.82(c) (continued)

- 2) All payments received by the Department shall be credited first to unpaid installment amounts (rather than to penalty or interest), beginning with the most delinquent installments.
- d) Reporting Requirements, Penalty, and Maintenance of Records
 - 1) After June 30 of each State fiscal year, and on or before September 30 of the succeeding State fiscal year, every developmentally disabled care provider subject to an assessment under subsection (b) above shall file a report with the Department. The report shall be on a form prepared by the Department. The report shall include the adjusted gross developmentally disabled care revenue from the State fiscal year just ended and shall be utilized by the Department to calculate the assessment for the State fiscal year commencing on the preceding July 1. If a developmentally disabled care provider operates or maintains more than one developmentally disabled care facility, a separate report shall be filed for each facility. In the case of a developmentally disabled care provider existing as a corporation or legal entity other than an individual, the report filed by it shall be signed by its president, vice-president, secretary, or treasurer or by its properly authorized agent.

- 2) If the developmentally disabled care provider fails to file its report for a State fiscal year on or before the due date of the report, there shall, unless waived by the Department for reasonable cause, be added to the assessment imposed in subsection (b) above a penalty assessment equal to 25% of the assessment imposed for the year.

- 3) Every developmentally disabled care provider subject to an assessment under subsection (b) above shall keep records and books that will permit the determination of adjusted gross developmentally disabled care revenue on a State fiscal year basis. All such books and records shall be maintained for a minimum of three (3) years following the filing date of the assessment report and shall, at all times during business hours of the day, be subject to inspection by the Department or its duly authorized agents and employees.

- 4) Amended Assessment Reports. With the exception of amended assessment reports filed in accordance with subsections (d)(5) or (6) below, an amended assessment report must be filed within 30 calendar days of the original report due date. The amended report must be accompanied by a letter identifying the changes

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Section 140.82(d)(4) (continued)

and the justification for the amended report. The provider will be advised of any adjustments to the original annual assessment amount through a written notification from the Department. Penalties may be applied to the amount underpaid due to a filing error.

5) Submission of Financial Audit Statements. All developmentally disabled care providers are required to submit a copy of all financial statements audited by an external, independent auditor to the Department within ~~thirty~~-(30)-days of the close of such externally performed financial audits. If the provider's year end does not coincide with the June 30th ending date for the ~~tax~~ assessment report, the provider must submit all financial audits covering the tax report period. An amended ~~tax~~ assessment report must accompany such external financial audit statements if the data submitted on the initial tax report changes based upon the findings of such external financial audits and as indicated in the audited external financial statements. Penalties may be applied to the amount underpaid due to a filing error.

6) Reconsideration of Adjusted Tax. If the Department, through an audit conducted by the Department or its agent within ~~three~~ years after the end of the fiscal year in which the assessment was due, changes the ~~tax~~ assessment liability of a developmentally disabled care provider, the developmentally disabled care provider may request a review or reconsideration of the adjusted ~~tax~~ assessment within ~~thirty~~-(30)-days of the Department's notification of the change in ~~tax~~ assessment liability. Requests for reconsideration of the ~~tax~~ assessment adjustment shall not be considered if such requests are not postmarked on or before the end of the ~~thirty~~-(30)-day review period. Penalties may be applied to the amount underpaid due to a filing error.

e) Procedure for Partial Year Reporting/Operating Adjustments

1) Cessation of business during the fiscal year in which the ~~tax~~ assessment is being paid. For a developmentally disabled care provider who ceases to conduct, operate, or maintain a facility ~~in receipt~~ for which the person is subject to assessment under subsection (b) above, the assessment for the State fiscal year in which the cessation occurs shall be adjusted by multiplying the assessment computed under subsection (d) above by a fraction, the numerator of which is the number of days in the year during which the provider conducts, operates, or maintains

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Section 140.82(e)(1) (continued)

the facility and the denominator of which is 365. The person shall file a final, amended report with the Department not more than 90 calendar days after the cessation, reflecting the adjustment and shall pay with the final report the assessment for the year as so adjusted, to the extent not previously paid.

2) Commencing of business during the fiscal year in which the ~~tax~~ assessment is being paid. A developmentally disabled care provider who commences conducting, operating, or maintaining a facility for ~~of~~ which the person is subject to assessment under subsection (b) above, shall file an initial return for the State fiscal year in which the commencement occurs within 90 30 calendar days thereafter and shall pay the assessment under subsection (d) above as computed by the Department in equal installments on the due date of the initial assessment determination and on the regular installment due dates for the State fiscal year occurring after the due date of the initial assessment determination. In determining the annual assessment amount for the provider the Department shall develop hypothetical annualized revenue projections based upon geographic location, facility size and patient case mix. The assessment determination made by the Department is final.

3) Partial Fiscal Year Operation Adjustment. A developmentally disabled care provider that did not conduct, operate, or maintain a facility throughout the entire fiscal year reporting period, the assessment for the following State fiscal year shall be annualized based on the provider's actual developmentally disabled care revenue for the portion of the reporting period the facility was operational (dividing adjusted developmentally disabled care revenue by the number of days the facility was in operation and then multiplying that amount by 365). Developmentally disabled care revenue realized by a prior provider from the same facility during the fiscal year shall be used in the annualization equation, if available.

4) Change in Ownership and/or Operators. The full quarterly assessment must be paid on the designated due dates regardless of changes in ownership or operators. Liability for the payment of the assessment amount (including past due assessments and any interest or penalties that may have accrued against the amount) rests on the developmentally disabled care provider currently operating or maintaining the developmentally disabled care facility regardless if these amounts were incurred by the current owner or were incurred by previous owners. Collection of delinquent assessment fees from previous providers will be

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Section 140.82(e)(4) (continued)

made against the current provider. Failure of the current provider to pay any outstanding assessment liabilities incurred by previous providers shall result in the application of penalties described in subsection (f)(1) of this Section.

f) Penalties

- 1) Any facility that fails to pay the full amount of an installment when due shall be charged, unless waived by the Department for reasonable cause, a penalty equal to 5% of the amount of the installment not paid on or before the due date, plus 5% of the portion thereof remaining unpaid on the last day of each month thereafter, not to exceed 100% of the installment amount not paid on or before the due date.

- 2) Within ~~forty-five~~ (45) days from the due date, the Department may begin recovery actions against delinquent facilities participating in the Medicaid Program. Payments may be withheld from the facility until the entire provider fee assessment, including any penalties, is satisfied, or until a reasonable repayment schedule has been approved by the Department. If a reasonable agreement cannot be reached, or if the facility fails to comply with an agreement the Department reserves the right to recover any outstanding provider assessment, interest and penalty by recouping the amount or a portion thereof from the provider's future payments from the Department. The provider may appeal this recoupment in accordance with Department rules contained in 89 Illinois Admin. Code 104. The Department has the right to continue recoupment during the appeal process. Penalties pursuant to subsection (f)(1) above will continue to accrue during the recoupment process. Recoupment proceedings against the same facility two times in a fiscal year may be cause for termination from the Program. Failure by the Department to initiate recoupment activities within 45 days shall not reduce the provider's liabilities nor shall it preclude the Department from taking action at a later date.

- 3) If the facility does not participate in the Medicaid Program, or is no longer doing business with the Department, or the Department cannot recover the full amount due through the claims processing system, within three months of the fee assessment due date, the Department may begin legal action to recover the monies, including penalties and interest owed, plus court costs.

g) Delayed Payment - Groups of Facilities.

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Section 140.82(g) (continued)

The Director may establish delayed payment of fees assessments and/or waive the payment of interest and penalties for groups of facilities when:

- 1) the State delays payments to facilities due to problems related to state cash flow, or
- 2) a cash flow bond pool's or any other group financing plans' requests from providers for loans are in excess of its scheduled proceeds such that a significant number of facilities will be unable to obtain a loan to pay the fee assessment.

h) Delayed Payment - Individual Facilities

In addition to the provisions of subsection (g) above, the Director may delay fees assessments for individual facilities that are unable to make timely payments under this Section due to financial difficulties. No delayed payment arrangements shall extend beyond the last business day of the calendar quarter following the quarter in which the assessment was to have been received by the Department as described in subsection (c) above.

- 1) Criteria. Delayed payment provisions may be instituted only under extraordinary circumstances. Delayed payment provisions shall be made only to qualified facilities who meet all of the following requirements:

- A) the facility has experienced an emergency which necessitates institution of delayed payment provisions. Emergency in this instance is defined as a circumstance under which institution of the payment and penalty provisions described in subsections (c)(1), (c)(2), (f)(1), (f)(2) and (f)(3) above would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:

- i) Department system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the facility's ability to provide further services to clients is severely impaired;
- ii) cash flow problems encountered by a facility which are unrelated to Department technical system problems and which result in extensive financial problems to a

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Section 140.82(h)(1)(A)(ii) (continued)

- facility adversely impacting on its ability to serve its clients.
- B) the facility serves a significant number of clients under the Medical Assistance Program. Significant in this instance means:
- i) 85 percent or more of their residents must be eligible for public assistance;
 - ii) a government-owned facility, which meets the cash flow criteria under subsection (h)(1)(A)(ii) ~~above~~;
 - iii) a provider who has filed for Chapter 11 bankruptcy, which meets the cash flow criterion under subsection (h)(1)(A)(ii) above.
- C) the facility must file a delay of payment request as defined in subsection (h)(3)(A) below, and the ~~request~~ request must include a Cash Position Statement which is based upon current assets, current liabilities and other data for a date which is less than ~~sixty~~ 60 days prior to the date of filing. Any liabilities payable to owners or related parties must not be reported as current liabilities on the Cash Position Statement. A deferral of assessment payments will be denied if any of the following criteria are met:
- i) the ratio of current assets divided by current liabilities is greater than 2.0;
 - ii) cash, short term investments and long term investments equal or exceed the total of accrued wages payable and the assessment payment. Long term investments which are unavailable for expenditure for current operations due to donor restrictions or contractual requirements will not be used in this calculation;
 - iii) cash or other assets has been distributed during the previous 90 days to owners or related parties in an amount equal to or exceeding the assessment payment for dividends, salaries in excess of those allowable under Section 140.541 or payments for purchase of goods or services in excess of cost as defined in Section 140.537.

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Section 140.82(h)(1) (continued)

- D) the facility, with the exception of government owned facilities, must show evidence of denial of an application to borrow the assessment funds through a cash flow bond pool or financial institutions such as a commercial bank. The denial must be 90 days old or less.
- E) the facility must sign an agreement with the Department which specifies the terms and conditions of the delayed payment provisions. The agreement shall contain the following provisions:
- i) specific reason(s) for institution of the delayed payment provisions;
 - ii) specific dates on which payments must be received and the amount of payment which must be received on each specific date described;
 - iii) the interest or a statement of interest waiver as described in subsection (h)(5) below that shall be due from the facility as a result of institution of the delayed payment provisions;
 - iv) a certification stating that, should the entity be sold, the new owners will be made aware of the liability and any agreement selling the entity will include provisions that the new owners will assume responsibility for repaying the debt to the Department according to the original agreement;
 - v) a certification stating that all information submitted to the Department in support of the delayed payment request is true and accurate to the best of the signator's knowledge; and
 - vi) such other terms and conditions that may be required by the Department.
- 2) A facility which does not meet the above criteria may request a delayed payment schedule and/or the waiver of interest and penalties. The Director may approve the request, notwithstanding the facility not meeting the above criteria, upon a sufficient showing of financial difficulties and good cause by the facility. If the request for a delayed payment schedule and/or waiver of interest and penalties is approved, all other conditions of this subsection (h) shall apply.

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Section 140.82(h) (continued)

3) Approval Process

A) In order to receive consideration for delayed payment provisions, facilities must submit their request in writing (telefax requests are acceptable) to the Bureau of Program and Reimbursement Analysis. The request must be received as follows: delayed payment requests for installments due on September 30 of the year must be received on or before September 15 of the year; delayed payment requests for installments due on December 31 of the year must be received on or before December 10 of the year; delayed payment requests for installments due on March 31 of the year must be received on or before March 11 of the year; and delayed payment requests for installments due on June 30 of the year must be received on or before June 4 of the year. Requests must be complete and contain all required information before they are considered to have met the time requirements for filing a delayed payment request. All telefax requests must be followed up with original written requests postmarked no later than the date of the telefax. The request must include:

- i) an explanation of the circumstances creating the need for the delayed payment provisions;
 - ii) supportive documentation to substantiate the emergency nature of the request and risk of irreparable harm to the clients; and
 - iii) specification of the specific arrangements requested by the facility.
- B) The facility shall be notified by the Department, in writing prior to the assessment due date, of the Department's decision with regard to the request for institution of delayed payment provisions. An agreement shall be issued to the facility for all approved requests. The agreement must be signed by the administrator, owner or other authorized representative and be received by the Department prior to the first scheduled payment date listed in such agreement.

- 4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) of this Section may be waived upon approval of the facility's request for institution of delayed payment provisions. In the event a facility's request for institution

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Section 140.82(h)(4) (continued)

of delayed payment provisions is approved and the Department has received the signed agreement in accordance with subsection (h)(3)(B) above, such penalties shall be permanently waived for the subject quarter unless the facility fails to meet all of the terms and conditions of the agreement. In the event the facility fails to meet all of the terms and conditions of the agreement, the agreement shall be considered null and void and such penalties shall be fully reinstated.

- 5) Interest. The delayed payments shall include interest at a rate not to exceed the State of Illinois borrowing rate. The applicable interest rate shall be identified in the agreement described in subsection (h)(1)(E) above. The interest may be waived by the Director if the facility's current ratio, as described in subsection (h)(1)(C) above is 1.5 or less and the facility meets the criteria in subsections (h)(1)(A) and (B) above. Any such waivers granted shall be expressly identified in the agreement described in subsection (h)(1)(E) above.
- 6) Subsequent Delayed Payment Arrangements. Once a facility has requested and received approval for delayed payment arrangements, the facility shall not receive approval for subsequent delayed payment arrangements until such time as the terms and conditions of any current delayed payment agreement have been satisfied or unless the provider is in full compliance with the terms of the current delay of payment agreement. The waiver of penalties described in subsection (h)(4) above shall not apply to a facility that has not satisfied the terms and conditions of any current delayed payment agreement.

i) Administration; enforcement provisions

Pursuant to Section 5C-6 of P.A. 86-861, to the extent practicable, the Department shall administer and enforce P.A. 86-861 and P.A. 88-88, and collect the assessments, interest, and penalty assessments imposed under the law, using procedures employed in its administration of this Code generally and, as it deems appropriate, in a manner similar to that in which the Department of Revenue administers and collects the retailers' occupation tax under the Retailers' Occupation Tax Act ("ROTA").

- j) Nothing in P.A. 88-88 shall be construed to prevent the Department from collecting all amounts due under this Section pursuant to an assessment imposed before the effective date of P.A. 88-88.

k) Definitions

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Section 140.82(k) (continued)

- 1) "Adjusted gross developmentally disabled care revenue" means the developmentally disabled care provider's total revenue for inpatient residential services, less contractual allowances and discounts on patients' accounts, but does not include non-patient revenue from sources such as contributions, donations or bequests, investments, day training services, television and telephone service, rental of facility space, or sheltered care revenue. Adjusted gross developmentally disabled care revenue must be reported on an accrual basis for the tax reporting period. All patient revenue accrued during the tax reporting period must be included even though reimbursement may occur after the tax reporting period. Patient revenue must be reported on a basis that is consistent with methods used on the ~~hospital's~~ facility's last two (2) cost reports.
- 2) "Contractual Allowance" means the difference between charges at established rates and the amount estimated to be paid by third party payors or patients, as appropriate, pursuant to agreements/contracts with the developmentally disabled care provider; courtesy and policy discounts provided to employees, medical staff and clergy; and charity care, but "contractual allowance" does not mean any Provider Participation fees/taxes paid to the Illinois Department of Public Aid.
- 3) "Department" means the Illinois Department of Public Aid.
- 4) "Developmentally disabled care facility" means an intermediate care facility for the mentally retarded within the meaning of Title XIX of the Social Security Act, whether public or private and whether organized for profit or not-for-profit, but shall not include any facility operated by the State.
- 5) "Developmentally disabled care provider" means a person conducting, operating, or maintaining a developmentally disabled care facility. For this purpose, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian or other representative appointed by order of any court.
- 6) "Facility" means all intermediate care facilities as defined under "Developmentally disabled care facility" above.
- 7) "Fund" means the Developmentally Disabled Care Provider Fund.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

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Section 140.84 Long Term Care Provider Fund

a) Purpose and Contents

- 1) The Long Term Care Provider Fund was created in the State Treasury upon enactment of Public Act 87-861 and Public Act 88-88. Interest earned by the Fund shall be credited to the Fund. The fund shall not be used to replace any funds appropriated to the Medicaid program by the General Assembly.
- 2) The Fund is created for the purpose of receiving and disbursing monies in accordance with this Section and Public Act 87-861 and Public Act 88-88.
- 3) The Fund shall consist of:
 - A) All monies collected or received by the Department under ~~subsection subsections~~ (b) below;
 - B) All federal matching funds received by the Department as a result of expenditures made by the Department that are attributable to monies deposited in the Fund;
 - C) Any interest or penalty levied in conjunction with the administration of the Fund;
 - D) All other monies received for the Fund from any other source, including interest earned thereon; and
 - E) All monies transferred from the Medicaid Long Term Care Provider Participation Fee Trust Fund; and
 - F) All monies transferred from the Tobacco Products Tax Act.

b) License Fee Provider-Assessments

Beginning on July 1, 1992 1993, a nursing home license fee assessment is imposed upon each long-term-care nursing home provider for the State fiscal year beginning on July 1, 1992 1993 and ending on June 30, 1993 1995, in an amount equal to \$1.50 for each licensed bed day for the calendar quarter in which the payment is due. ~~\$6.20 times the number of occupied bed-days for the most recent calendar year ending before the beginning of that State fiscal year. Occupied bed-days will be based upon the long-term-care provider's annualized occupied bed-days reported on the long-term-care provider tax form to be filed by a date designated by the Department. All nursing home beds subject to licensure under the Nursing Home Care Act or the Hospital Licensing Act, with the exception of swing beds, as defined~~

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Section 140.84(b) (continued)

in subsection (k)(8) of this Section will be used to calculate the licensed bed days for each quarter. This license fee shall not be billed or passed on to any resident of a nursing home operated by the nursing home provider. Changes in the number of licensed beds will be reported to the Department quarterly, as described in subsection (d)(1) below. The Department reserves the right to audit the reported data.

c) Payment of License Fee Assessment Due

- 1) The license fee assessment described in subsection (b) above shall be due and payable in quarterly installments, each equaling one-fourth of the assessment for the year on September 30 10, December 31 10, March 31 10, and June 30 10 of the year. License fee assessment payments postmarked on the due date will be considered as paid on time.
- 2) All payments received by the Department shall be credited first to unpaid installment amounts (rather than to penalty or interest), beginning with the most delinquent installments.
- 3) County nursing homes directed and maintained pursuant to Section 5-1005 of the Counties Code may meet their license fee assessment obligation by the county government certifying to the Department that county expenditures have been obligated for the operation of the county nursing home in an amount at least equal to the amount of the license fee assessment. County governments wishing to provide such certification must:
 - A) Sign a certification form certifying that the funds represent expenditures eligible for federal financial participation under Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), and that these funds are not federal funds, or are federal funds authorized by federal law to be used to match other federal funds;
 - B) Submit the certification document to the Department once a year along with a copy of that portion of the county budget showing the funds appropriated for the operation of the county nursing home. These documents must be submitted within 30 days of the final approval of the county budget. The county budget and/or budgets covering the State fiscal year of July 1, 1992 1993, through June 30, 1993 1995, must be submitted by a date designated by the Department;

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Section 140.84(c)(3) (continued)

- C) Submit the monthly claim form in the amount of the rate established by the Department minus any third party liability amount. This amount will be reduced by one-twelfth of the annual assessment an amount determined by the amount certified and the number of months remaining in the fiscal year, prior to payment because a certification statement was provided in lieu of an actual license fee assessment payment; and
- D) Make records available upon request to the Department and/or the United States Department of Health and Human Services pertaining to the certification of county funds.
 - d) Reporting Requirements, Penalty, and Maintenance of Records
 - 1) After December 31 of each year, and on or before March 31 of the succeeding year, every long-term care on or before the due dates described in subsection (c)(1), each nursing home provider subject to a license fee under subsection (b) of this Section shall file a report with the Department reflecting any changes in the number of licensed beds occurring during the reporting quarter. The report shall be on a form prepared by the Department. The changes will be reported quarterly and shall be submitted with the revised quarterly license fee payment. For the purpose of calculating the license fee described in subsection (b) above, all changes in licensed beds will be effective upon approval of the change by the Illinois Department of Public Health. Documentation showing the change in licensed beds, and the date the change was approved by the Illinois Department of Public Health, must be submitted to the Department of Public Aid with the licensed bed change form. The report shall include the occupied bed days for the calendar year just ended and shall be utilized by the Department to calculate the assessment for the State fiscal year commencing on the next July 1, except that the report for the State fiscal year commencing July 1, 1992, including occupied bed days for calendar year 1991 shall be filed on or before September 30, 1992. If a long-term care nursing home provider operates or maintains more than one long-term care facility nursing home, a separate report shall be filed for each facility. In the case of a long-term care nursing home provider existing as a corporation or legal entity other than an individual, the report filed by it shall be signed by its president, vice-president, secretary, or treasurer or by its properly authorized agent.

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Section 140.84(d) (continued)

- 2) If the ~~long-term-care~~ nursing home provider fails to file its report for a State fiscal year on or before the due date of the report, there shall, unless waived by the Department for reasonable cause, be added to the ~~license fee assessment~~ imposed in subsection (b) above a penalty ~~fee assessment~~ equal to 25% of the ~~license fee assessment~~ imposed for the year.
- 3) Every ~~long-term-care~~ nursing home provider subject to a ~~license fee assessment~~ under subsection (b) above shall keep records and books that will permit the determination of ~~occupied~~ licensed bed days on a ~~calendar-year~~ quarterly basis. All such books and records shall be maintained for a minimum of three (3) years following the filing date of the ~~license fee assessment~~ report and shall, at all times during business hours of the day, be subject to inspection by the Department or its duly authorized agents and employees.
- 4) Amended ~~License Fee Assessment~~ Reports. With the exception of amended ~~license fee assessment~~ reports filed in accordance with subsections (d)(5) ~~or~~ (6) below, an amended ~~license fee assessment~~ report must be filed within 30 calendar days of the original report due date. The amended report must be accompanied by a letter identifying the changes and the justification for the amended report. The provider will be advised of any adjustments to the original annual ~~license fee assessment~~ amount through a written notification from the Department. Penalties may be applied to the amount underpaid due to a filing error.
- 5) ~~Submission of Financial Audit Statements~~---All ~~long-term-care~~ nursing home providers are required to submit a copy of all financial statements audited by an external independent auditor to the Department within thirty (30) days of the close of such externally performed financial audit---if the provider in year end does not coincide with the December 31st ending date for the tax report, the provider must submit all financial audits covering the tax report period---An amended tax report must accompany such external financial audit statements if the data submitted on the initial tax report changes based upon the findings of such external financial audit and as indicated in the audited external financial statement---Penalties may be applied to the amount underpaid due to a filing error.
- 5)6) Reconsideration of Adjusted License Fee Tax. If the Department, through an audit conducted by the Department or its agent within three years after the end of the fiscal year in which the

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Section 140.84(d)(5) (continued)

- assessments ~~license fee~~ was due, changes the ~~license fee tax~~ liability of a ~~long-term-care~~ nursing home provider, the ~~long term-care~~ nursing home provider may request a review or reconsideration of the adjusted ~~license fee tax~~ within thirty (30) days of the Department's notification of the change in ~~license fee tax~~ liability. Requests for reconsideration of the ~~license fee tax~~ adjustment shall not be considered if such requests are not postmarked on or before the end of the thirty (30) day review period. Penalties may be applied to the amount underpaid due to a filing error.
- e) Procedure for Partial Year Reporting/Operating Adjustments
 - 1) Cessation of business during the ~~fiscal year~~ quarter in which the ~~license fee tax~~ is being paid and the closure date has been set. A ~~long-term-care~~ nursing home provider who ceases to conduct, operate, or maintain a facility in respect for which the person is subject to the ~~license fee assessment~~ imposed under subsection (b) above, the ~~assessment for the State fiscal year~~ in which the cessation occurs be adjusted by multiplying the ~~assessment computed under subsection (d) above by a fraction~~ the numerator of which is the number of days in the year during which the provider conducted operation or maintained the facility and the denominator of which is 365. The person and for which the closure date for the facility has been set, shall file a final amended report with the Department on or before the due date for the quarter in which the closure is to occur, not more than 60 calendar days after the cessation. The report will reflect reflecting the adjusted adjustment number of days the facility is open during the reporting quarter and shall be submitted with the final quarterly payment pay with the final report the assessment for the year as so adjusted to the extent not previously paid. Example: A facility is set to close on September 24. On or before the due date of September 10, for the reporting quarter of July 1 through September 30, the facility will submit a final report reflecting 86 days of operation (July 1 through September 24) and the corresponding quarterly license fee payment.
 - 2) Cessation of business after the quarterly due date. A nursing home provider who ceases to conduct, operate, or maintain a facility for which the person is subject to the license fee imposed under subsection (b) above, and for which closure occurs after the due date for the reporting quarter, but prior to the last day of the reporting quarter, shall file an amended final report with the Department within 30 days of the closure date.

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Section 140.84(e)(2) (continued)

The amended report will reflect the number of days the facility was operational during the reporting quarter and the revised license fee amount. Upon verifying the data submitted on the amended report, the Department will issue a refund for the amount overpaid. Example: On December 10 a facility pays the license fee for 92 days covering the reporting quarter of October 1 through December 31. The facility closes on December 27. An amended report reflecting 88 days, the actual number of days the facility was operational during the quarter (October 1 through December 27), must be filed with the Department.

- 3) Cessation of business prior to the quarterly due date. A nursing home provider who ceases to conduct, operate, or maintain a facility for which the person is subject to the license fee imposed under subsection (b) above, and for which closure occurs prior to the due date for the reporting quarter, shall file a final report with the Department within 30 days of the closure date. The final report will reflect the number of days the facility was operational during the reporting quarter and the corresponding final license fee amount. Closure dates will be verified with the Department of Public Health, and if necessary adjustments will be made to the final license fee due. Example: Facility closes on January 17. On or before February 17, the facility must file a final report for the reporting quarter of January 1 through March 31. The report would reflect 17 days of operation (January 1 through January 17) during the quarter and must be accompanied by the final license fee payment for the facility.

- 4) Commencing of business during the fiscal year in which the license fee tax is being paid. A long-term-care nursing home provider who commences conducting, operating, or maintaining a facility for which the person is subject to the license fee imposed under subsection (b) above, shall file an initial report for the State-fiscal-year reporting quarter in which the commencement occurs within 90 calendar days thereafter and shall pay the license fee assessment under subsection (d) above as computed by the Department in equal installments on the due date of the initial assessment determination and on the regular installment due dates for the State-fiscal year occurring after the due date of the initial assessment determination. In determining the annual assessment amount for the provider the Department shall develop hypothetical annualized revenue projections based upon geographic location, facility size and patient case mix. The assessment determination made by the Department is final.

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Section 140.84(e) (continued)

- 3) Partial Calendar Year Operation-Adjustment--A long-term-care provider that did not conduct operation or maintain a facility throughout the entire calendar year reporting period, the assessment for the following State-fiscal year shall be assessed based on the provider's actual occupied bed-days for the portion of the reporting period the long-term-care facility was operational (dividing adjusted-occupied bed-days by the number of days the facility was in operation and then multiplying that figure by 365). Occupied bed-days realized by a prior provider from the same facility during the calendar year shall be used in the annualization equation if available.

- 5) Change in Ownership and/or Operators. The full quarterly assessment/license fee must be paid on the designated due dates regardless of changes in ownership or operators. Liability for the payment of the assessment/license fee amount (including past due assessment/license fees and any interest or penalties that may have accrued against the amount) rests on the nursing home provider currently operating or maintaining the nursing facility regardless if these amounts were incurred by the current owner or were incurred by previous owners. Collection of delinquent assessment/license fees from previous providers will be made against the current provider. Failure of the current provider to pay any outstanding assessment/license fee liabilities incurred by previous providers shall result in the application of penalties described in subsection (f)(1) of this Section.

f) Penalties

- 1) Any long-term-care nursing home provider that fails to pay the full amount of an installment when due, or fails to report a change in licensed beds approved by the Department of Public Health prior to the due date of the installment, shall be charged, unless waived by the Department for reasonable cause, a penalty equal to 5% of the amount of the installment not paid on or before the due date, plus 5% of the portion thereof remaining unpaid on the last day of each month thereafter, not to exceed 100% of the installment amount not paid on or before the due date.
- 2) Within forty-five (45) days from the due date, the Department may begin recovery actions against delinquent long-term-care nursing home providers participating in the Medicaid Program. Payments may be withheld from the provider until the entire license provider fee, including any penalties, is satisfied or

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until a reasonable repayment schedule has been approved by the Department. If a reasonable agreement cannot be reached, or if a provider fails to comply with an agreement the Department reserves the right to recover any outstanding license fee provider-assessment, interest and penalty by recouping the amount or a portion thereof from the provider's future payments from the Department. The provider may appeal this recoupment in accordance with the Department rules contained in 89 ~~Illinois~~ Adm. Ill. Adm. Code 104. The Department has the right to continue recoupment during the appeal process. Penalties pursuant to subsection (f)(1) above will continue to accrue during the recoupment process. Recoupment proceedings against the same ~~long-term-care~~ nursing home provider two times in a fiscal year may be cause for termination from the Program. Failure by the Department to initiate recoupment activities within 45 days shall not reduce the provider's liabilities nor shall it preclude the Department from taking action at a later date.

- 3) If the ~~long-term-care~~ nursing home provider does not participate in the Medicaid Program, or is no longer doing business with the Department, or the Department cannot recover the full amount due through the claims processing system, within three months of the license fee due date, the Department may begin legal action to recover the monies, including penalties and interest owed, plus court costs.

g) Delayed Payment - Groups of Facilities

The Director may establish delayed payment of fees and/or waive the payment of interest and penalties for groups of facilities when:

- 1) the State delays payments to facilities due to problems related to state cash flow, or
- 2) a cash flow bond pool's or any other group financing plans' requests from providers for loans are in excess of its scheduled proceeds such that a significant number of facilities will be unable to obtain a loan to pay the license fee.

h) Delayed Payment - Individual Facilities

In addition to the provisions of subsection (g) above, the Director may delay license fees for individual facilities that are unable to make timely payments under this Section due to financial difficulties. No delayed payment arrangements shall extend beyond

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Section 140.84(h) (continued)

the last business day of the calendar quarter following the quarter in which the license fee ~~assessment~~ was to have been received by the Department as described in subsection (c) above.

- 1) Criteria. Delayed payment provisions may be instituted only under extraordinary circumstances. Delayed payment provisions shall be made only to qualified facilities who meet all of the following requirements:
 - A) the facility has experienced an emergency which necessitates institution of delayed payment provisions. Emergency in this instance is defined as a circumstance under which institution of the payment and penalty provisions described in subsections (c)(1), (c)(2), (f)(1), (f)(2) and (f)(3) above would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:
 - i) Department system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the facility's ability to provide further services to clients is severely impaired;
 - ii) cash flow problems encountered by a facility which are unrelated to Department technical system problems and which result in extensive financial problems to a facility adversely impacting on its ability to serve its clients.
 - B) the facility serves a significant number of clients under the Medical Assistance Program. Significant in this instance means:
 - i) 85 percent or more of their residents must be eligible for public assistance;
 - ii) a government-owned facility, which meets the cash flow criterion under subsection (h)(1)(A)(ii) above.
 - iii) a provider who has filed for Chapter 11 bankruptcy, which meets cash flow criteria under subsection (h)(1)(A)(ii) above.

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Section 140.84(h)(1) (continued)

C) the facility must file a delay of payment request as defined under subsection (h)(3)(A) below and the request must include a Cash Position Statement which is based upon current assets, current liabilities and other data for a date which is less than ~~sixty~~-60 days prior to the date of filing. Any liabilities payable to owners or related parties must not be reported as current liabilities on the Cash Position Statement. A deferral of license fee ~~assessment~~ payments will be denied if any of the following criteria are met:

- i) the ratio of current assets divided by current liabilities is greater than 2.0;
- ii) cash, short term investments and long term investments equal or exceed the total of accrued wages payable and the ~~license fee assessment~~ payment. Long term investments which are unavailable for expenditure for current operations due to donor restrictions or contractual requirements will not be used in this calculation;
- iii) cash or other assets has been distributed during the previous 90 days to owners or related parties in an amount equal to or exceeding the ~~license fee assessment~~ payment for dividends, salaries in excess of those allowable under Section 140.541 or payments for purchase of goods or services in excess of cost as defined in Section 140.537.

D) the facility, with the exception of government owned facilities, must show evidence of denial of an application to borrow license fee ~~assessment~~ funds through a cash flow bond pool or financial institutions such as a commercial bank. The denial must be 90 days old or less.

E) the facility must sign an agreement with the Department which specifies the terms and conditions of the delayed payment provisions. The agreement shall contain the following provisions:

- i) specific reason(s) for institution of the delayed payment provisions;
- ii) specific dates on which payments must be received and the amount of payment which must be received on each specific date described;

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iii) the interest or a statement of interest waiver as described in subsection (h)(5) below that shall be due from the facility as a result of institution of the delayed payment provisions;

iv) a certification stating that, should the entity be sold, the new owners will be made aware of the liability and any agreement selling the entity will include provisions that the new owners will assume responsibility for repaying the debt to the Department according to the original agreement;

v) a certification stating that all information submitted to the Department in support of the delayed payment request is true and accurate to the best of the signator's knowledge; and

vi) such other terms and conditions that may be required by the Department.

2) A facility which does not meet the above criteria may request a delayed payment schedule and/or the waiver of interest and penalties. The Director may approve the request, notwithstanding the facility not meeting the above criteria, upon a sufficient showing of financial difficulties and good cause by the facility. If the request for a delayed payment schedule and/or waiver of interest and penalties is approved, all other conditions of this subsection (h) shall apply.

3) Approval Process

A) In order to receive consideration for delayed payment provisions, facilities must submit their request in writing (telex requests are acceptable) to the Bureau of Program and Reimbursement Analysis. The request must be received as follows: delayed payment requests for installments due on September 30 10 of the year must be received on or before ~~September-15~~ August 20 of the year; delayed payment requests for installments due on December 31 10 of the year must be received on or before ~~December-10~~ November 22 of the year; delayed payment requests for installments due on March 31 10 of the year must be received on or before ~~March-5~~ February 18 of the year; and delayed payment requests for installments due on June 30 10 of the year must be received on or before ~~June-4~~ May 20 of the year. Requests must be complete and contain all required information before they

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are considered to have met the time requirements for filing a delayed payment request. All telefax requests must be followed up with original written requests by certified mail postmarked no later than the date of the telefax. The request must include:

- i) an explanation of the circumstances creating the need for the delayed payment provisions;
- ii) supportive documentation to substantiate the emergency nature of the request including a cash position statement as defined in subsection (h)(1)(C) above; a denial of application to borrow the ~~license fee~~ ~~assessment~~ as defined in subsection (h)(1)(D) above and an explanation risk of irreparable harm to the clients; and
- iii) specification of the specific arrangements requested by the facility.

B) The facility shall be notified by the Department, in writing prior to the ~~license fee assessment~~ due date, of the Department's decision with regard to the request for institution of delayed payment provisions. An agreement shall be issued to the facility for all approved requests. The agreement must be signed by the administrator, owner or other authorized representative and be received by the Department prior to the first scheduled payment date listed in such agreement.

4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) above may be waived upon approval of the facility's request for institution of delayed payment provisions. In the event a facility's request for institution of delayed payment provisions is approved and the Department has received the signed agreement in accordance with subsection (h)(3)(B) above, such penalties shall be permanently waived for the subject quarter unless the facility fails to meet all of the terms and conditions of the agreement. In the event the facility fails to meet all of the terms and conditions of the agreement, the agreement shall be considered null and void and such penalties shall be fully reinstated.

5) Interest. The delayed payments shall include interest at a rate not to exceed the State of Illinois borrowing rate. The applicable interest rate shall be identified in the agreement

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Section 140.84(h)(5) (continued)

described in subsection (h)(1)(E) above. The interest may be waived by the Director if the facility's current ratio, as described in subsection (h)(1)(C) above is 1.5 or less and the facility meets the criteria in (h)(1)(A) and (B). Any such waivers granted shall be expressly identified in the agreement described in subsection (h)(1)(E) above.

6) Subsequent Delayed Payment Arrangements. Once a facility has requested and received approval for delayed payment arrangements, the facility shall not receive approval for subsequent delayed payment arrangements until such time as the terms and conditions of any current delayed payment agreement have been satisfied or unless the provider is in full compliance with the terms of the current delay of payment agreement. The waiver of penalties described in subsection (h)(4) above shall not apply to a facility that has not satisfied the terms and conditions of any current delayed payment agreement.

i) Administration; enforcement provisions

Pursuant to Section 5B-7 of P.A. 87-861, to the extent practicable, the Department shall administer and enforce P.A. 86-861 and P.A. 88-88, and collect the ~~license fees assessments~~, interest, and penalty fees ~~assessments~~ imposed under the law, using procedures employed in its administration of this Code generally and, as it deems appropriate, in a manner similar to that in which the Department of Revenue administers and collects the retailers' occupation tax under the Retailers' Occupation Tax Act ("ROTA").

j) Nothing in P.A. 88-88 shall be construed to prevent the Department from collecting all amounts due under this Section pursuant to an assessment imposed before the effective date of P.A. 88-88.

Exemptions

1) A long-term-care-provider which is a county with a population of more than 2,000,000 that makes intergovernmental transfer payments as provided in Section 15-3 of P.A. 87-861 shall be exempt from the assessment imposed by subsection (b) above unless the exemption is adjudged to be unconstitutional or otherwise invalid, in which case the county shall pay the assessment imposed by subsection (b) above for all assessment periods beginning on or after July 1, 1992, and the assessment so paid shall be creditable against the intergovernmental transfer payments.

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Section 140.84(j) (continued)

- 2) A sole community hospital provider, as defined in the regulations of the Illinois Department (89 Ill. Adm. Code 149.125(b)) as in effect on July 1, 1992, whether public or private and whether organized for profit or not for profit, operating a SNF/IDF unit within the hospital that is subject to licensure by the Illinois Department of Public Health under the Nursing Home Care Act or a hospital provider that provides skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act, shall be exempt from the assessment imposed by subsection (b) above, unless the exemption is adjudged to be unconstitutional or otherwise invalid, in which case the sole community hospital provider shall pay the assessment imposed by subsection (b) above. For the purpose of determining these sole community hospital providers that shall be exempt from the assessments imposed by subsection (b) above, the sole community hospital provider designation for FY 1993 (July 1, 1992 through June 30, 1993) will be effective on July 1, 1992 and shall apply to the period of July 1, 1992 through June 30, 1993.

k) Definitions

As used in this Section, unless the context requires otherwise:

- 1) "Department" means the Illinois Department of Public Aid.
- 2) "Fund" means the Long-Term Care Provider Fund.
- 3) "Long-term care facility" means (i) a skilled nursing or intermediate long-term care facility, whether public or private and whether organized for profit or not for profit, that is subject to licensure by the Illinois Department of Public Health under the Nursing Home Care Act, including a county nursing home directed and maintained under Section 5-1005 of the Counties Code; and (ii) a part of a hospital in which skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act are provided except that the term "long-term care facility" does not include a facility operated solely as an intermediate care facility for the mentally retarded within the meaning of Title XIX of the Social Security Act.
- 3) "Hospital provider" means a person licensed by the Department of Public Health to conduct, operate, or maintain a hospital, regardless of whether the person is a Medicaid provider. For purposes of this definition, "person" means any political

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Section 140.84(k)(3) (continued)

- subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.
- 4) "Intergovernmental transfer payment" means the payments established under Section 15-3 of P.A. 87-861, and includes without limitation payments payable under that Section for July, August, and September of 1992.
 - 4) "Licensed bed days" means, with respect to a nursing home provider, the sum for all nursing home beds, with the exception of swing beds, as described in subsection (k)(8) of this Section, of the number of days during a calendar quarter on which each bed is covered by a license issued to that provider under the Nursing Home Care Act or the Hospital Licensing Act.
 - 5) "Nursing home" means a skilled nursing or intermediate long-term care facility, whether public or private and whether organized for profit or not for profit, that is subject to licensure by the Illinois Department of Public Health under the Nursing Home Care Act, including a county nursing home directed and maintained under Section 5-1005 of the Counties Code; and a part of a hospital in which skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act are provided. However, the term "nursing home" does not include a facility operated solely as an intermediate care facility for the mentally retarded within the meaning on Title XIX of the Social Security Act.
 - 5) "Long-term care provider" means a person licensed by the Department of Public Health to operate and maintain a skilled nursing or intermediate long-term care facility or a hospital provider that provides skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act. For purposes of this paragraph, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court. "Hospital provider" means a person licensed by the Department of Public Health to conduct, operate, or maintain a hospital.

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Section 140.84(k) (continued)

6) "Occupied-bed-days" means the sum of all days during the year for which each bed is occupied by a resident (other than a resident receiving care at an intermediate care facility for the mentally retarded within the meaning of Title XIX of the Social Security Act), regardless of whether or not the facility receives payment for the day; "Occupied-bed-days may not be adjusted for bad debt; "Occupied-bed-days does not mean bed holds or shelter care bed days.

7) "Sole-Community-Hospital-Provider" means a hospital provider designated as a Medicaid Sole-Community-Provider as defined in 89-Ill-Adm-Gode-149.125(b) whether public or private and whether organized for profit or not for profit.

8) "Nursing home provider" means a person licensed by the Department of Public Health to operate and maintain a skilled nursing or intermediate long-term care facility which charges its residents, a third party payor, Medicaid, of Medicare for skilled nursing or intermediate long-term care services; or a hospital provider that provides skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act.

9) "Person" means, in addition to natural persons, any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.

10) "Swing-beds" means those beds for which a hospital provider has been granted an approval from the Federal Health Care Financing Administration to provide post-hospital extended care services (42 CFR 409.30, October 1, 1991) and be reimbursed as a swing-bed hospital (42 CFR 413.114, October 1, 1991).

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

Section 140.400 Payment to Practitioners, Nurses and Laboratories

a) This Section applies to physicians, dentists, nurses, optometrists, podiatrists, chiropractors and independent laboratories.

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Section 140.400(a) (continued)

1) Practitioners, nurses and independent laboratories are required to bill the Medical Assistance Program at the same rate they charge patients paying their own bills and patients covered by other third party payors.

2) A practitioner or nurse may bill only for services he personally provides or which are provided under his direct supervision in his office by his staff, so long as such practice is not in conflict with the Illinois Nursing Act of 1987 (Ill. Rev. Stat. 1989, ch. 111, par 3501 et seq.) and implementing regulations. A practitioner may not bill for services provided by another practitioner even though he may be in the employ of the other.

3) Payment will be made only in practitioner's or nurse's name or Department approved alternate payee.

4) Payments will be made according to a schedule of State-wide statewide pricing screens established by the Department of Public Aid, ~~except for covered services of a nurse midwife, which will be reimbursed for covered services at 70% of the established screen, and covered services provided by qualifying providers under the Healthy Moms/Healthy Kids Program, which will be reimbursed at enhanced rates (see subsection (b) below).~~ The pricing screens are to be established based on consideration of the market value of the service. In considering the market value, the Department will examine the costs of operations and material. Input from advisory groups designated by statute, generally recognized provider interest groups and the general public will be taken into consideration in determining the allocation of available funds to rate adjustments. Increases in rates are contingent upon funds appropriated by the General Assembly. Reductions or increases may be affected by changes in the market place or changes in funding available for the Medical Assistance Program. Screens will be related to the average State-wide statewide charge. The upper limit for services shall not exceed the lowest Medicare charge levels.

b) Providers who meet the qualifications for and enter into a Primary Care Provider Agreement for participation in the Healthy Moms/Healthy Kids Program, as described in Subpart G, will receive enhanced reimbursement in accordance with Section 140.930(a)(1).

b)c) The Department will distribute (initially and upon revision of the amounts) to practitioners, nurses and laboratories the maximum allowable amounts for the most commonly billed procedures codes.

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Section 140.400(c) (continued)

Interested individuals may request a copy of the maximum allowable amounts from the Department by directing the request to the Bureau of Medical-Presettitioner Comprehensive Health Services, Prescott E. Bloom Building, 201 South Grand Avenue East, Springfield, Illinois 62763-0001. In addition, a participating individual practitioner may request the maximum allowable amounts for less commonly billed specific procedures that relate to the individual's practice. This request must be in writing and identify specific procedure code(s) and associated descriptions.

(Source: Amended at 18 Ill. Reg. —, effective February 28, 1994)

Section 140.413 Limitation on Physician Services

- a) When provided in accordance with the specified limitations and requirements, the Department shall pay for the following services:

- 1) Termination of pregnancy -- only in those cases in which the physician has certified in writing to the Department that the procedure is necessary to preserve the life of the mother. All claims for reimbursement for abortions or induced miscarriages or premature births must be accompanied by the physician's written certification which specifies that the procedure is necessary for preservation of life of woman, or that the induced premature birth was to produce a live viable child and was necessary for the health of mother or her unborn child.

2) Sterilization

- A) Therapeutic sterilization -- only when the procedure is either a necessary part of the treatment of an existing illness, or is medically indicated as an accompaniment of an operation on the female genitourinary tract. Mental incapacity does not constitute an illness or injury in respect to this procedure.
- B) Nontherapeutic sterilization -- only for recipients age 21 or older. The physician must obtain the recipient's informed written consent in a language understandable to the recipient before performing the sterilization and must advise the recipient of the right to withdraw consent at any time prior to the operation. The operation shall be performed no sooner than 30 days and no later than 180 days following the date of the recipient's written informed consent except in cases of premature delivery or emergency

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Section 140.413(a)(2)(B) (continued)

abdominal surgery. An individual may consent to be sterilized at the time of premature delivery or emergency abdominal surgery if at least 72 hours have passed since informed consent was given.

- 3) End stage renal disease treatment (chronic hemodialysis and kidney transplantation) is limited to those recipients who have been determined medically eligible for such treatment by the Illinois Department of Public Health.
- 4) By-pass surgery for morbid obesity -- only with the prior approval of the Department. The Department shall approve payment for this service only in those cases in which it determines that obesity is exogenous in nature, the recipient has had the benefit of other therapy with no success, and endocrine disorders have been ruled out. (See Sections 140.40 through 140.42 for prior approval requirements.)
- 5) Psychiatric Services
 - A) Treatment -- when the services are provided by a physician who has been enrolled as an approved provider with the Department. Psychiatric treatment services are not covered services for Recipients of General Assistance or Aid to the Medically Indigent.
 - B) Consultation -- only when necessary to determine the need for psychiatric care. Services provided subsequent to the initial consultation must comply with the requirements for treatment.
- 6) Services provided to a recipient in his place of residence -- only when the recipient is physically unable to go to the physician's office.
- 7) Services provided to recipients in group care facilities by a physician other than the attending physician -- only emergency services provided when the attending physician of record is not available or when the attending physician has made referral with the recipient's knowledge and permission.
- 8) Services provided to recipients in a group care facility by a physician who derives a direct or indirect profit from total or partial ownership (or from other types of financial investment for profit in the facility -- only when occasioned by an emergency due to acute illness, unavailability of essential

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Section 140.413(a)(8) (continued)

treatment facilities in the vicinity for short-term care pending transfer, or when there is no comparable facility in the area.

- 9) Maternity care -- Payment shall be made for pre-natal and post-natal care ~~for mother and child~~ only when the following conditions are met:

A) the physician, whether based in a hospital, clinic, or individual practice, retains hospital delivery privileges or maintains a written referral arrangement with another physician who retains such privileges or has entered into an appropriate Healthy Moms/Healthy Kids Program provider agreement or receives payment authorization for referral from the Department's independent contractor, as described in Sections 140.928(a)(7) and 140.932(a);

B) the written referral agreement is kept on file and is available for inspection at the physician's place of business, and details procedures for timely transfer of medical records; and

C) maternal services are delivered in a manner consistent with the quality of care guidelines published by the American College of Obstetricians and Gynecologists in the current edition of the "Standards for Obstetric-Gynecologic Services" (1989 Edition), 409 12th Street, S.W., Washington, D.C. 20024-2188.

- 10) Physician services to children under age twenty-one

A) Payment shall be made only when the physician meets one or more of the following conditions. The physician:

- i) has admitting privileges at a hospital; or
- ii) is certified or is eligible for certification in pediatrics or family practice by the medical specialty board recognized by the American Board of Medical Specialties; or
- iii) is employed by or affiliated with a Federally Qualified Health Center; or
- iv) is a member of the National Health Service Corps; or

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v) has been certified by the Secretary of the Department of Health and Human Services as qualified to provide physicians' services to a child under 21 years of age; or

vi) has current, formal consultation and referral arrangements with a pediatrician or family practitioner for the purposes of specialized treatment and admission to a hospital. The written referral agreement is kept on file and is available for inspection at the physician's place of business, and details procedures for timely transfer of medical records; or

vii) has entered into a Healthy Moms/Healthy Kids Program provider agreement or receives payment authorization for referral from the Department's independent contractor described in Sections 140.928(a)(7) and 140.932(a).

B) The physician should notify the Department of the way in which he/she meets the above criteria; and

C) Services to children are delivered in a manner consistent with the standards of the American Academy of Pediatrics and rules as published by the Illinois Department of Public Health (77 Ill. Adm. Code 630, Maternal and Child Health Services; 77 Ill. Adm. Code 665, Child Health Examinations; 77 Ill. Adm. Code 675, Hearing Screening; 77 Ill. Adm. Code 685, Vision Screening).

11) Hysterectomy -- only if the individual has been informed, orally and in writing, that the hysterectomy will render her permanently incapable of reproducing and the individual has signed a written acknowledgement of receipt of the information. The Department will not pay for a hysterectomy which would not have been performed except for the purpose of rendering an individual permanently incapable of reproducing.

12) Selected surgical procedures

- A) Tonsillectomies or Adenoidectomies
- B) Hemorrhoidectomies
- C) Cholecystectomies

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- D) Disc Surgery/Spinal Fusion
- E) Hysterectomies
- F) Joint Cartilage Surgery/Meniscectomies
- G) Excision of Varicose Veins
- H) Submucous Resection/Rhinoplasty/Repair of Nasal System
- I) Mastectomies for Non-Malignancies
- J) Surgical procedures which generally may be performed in an outpatient setting (see Section 140.117) only if the Department authorizes payment. The Department will in some instances require that a second physician agree that the surgical procedure is medically necessary prior to approving payment for one of these procedures. The Department will require a second opinion when the attending physician has been notified by the Department that he will be required to obtain prior approval for payment for the surgeries listed. (See Sections 140.40 through 140.42 for prior approval requirements.) The Department will select physicians for this requirement based on the recommendation of a peer review committee that has reviewed the utilization pattern of the physician.

13) Mammography screening

- A) Covered only when ordered by a physician for screening by low-dose mammography for the presence of occult breast cancer under the following guidelines:
 - i) a baseline mammogram for women 35 through 39 years of age;
 - ii) a mammogram every one to two years for women 40 through 49 years of age; or
 - iii) a mammogram once per year for women 50 years of age or older.
- B) As used in this rule, "low-dose mammography" means the x-ray examination of the breast using equipment specifically designated for mammography that will meet appropriate radiological standards.

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- b) In cases where a physical examination by a second physician is needed, the Department will notify the recipient and designate a physician to perform the examination. Physicians will be subject to this requirement for six (6) months after which a request can be submitted to the peer review committee to consider removal of the prior approval requirement.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 140.460 Clinic Services

The following types of clinics are eligible to receive payment for clinic services:

- a) Hospital-based organized clinics;
- b) Encounter rate clinics;
- c) Pay-for-service clinics;
- d) Federally Qualified Health Centers (FQHC);
- e) Rural health clinics;
- f) Mental health clinic services (see Sections 140.452 through 140.456); and
- g) Healthy Moms/Healthy Kids Managed Care Clinics.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 140.461 Clinic Participation, Data and Certification Requirements

a) Hospital-based organized clinics must:

- 1) Have an administrative structure, staff program, physical setting, and equipment to provide comprehensive medical care;
- 2) Agree to assume complete responsibility for diagnosis and treatment of the patients accepted by the clinic, or provide, at no additional cost to the Department, for the acquisition of these services through contractual arrangements with external medical providers; and

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- 3) Be adjacent to or on the premises of the hospital and be licensed under the Hospital Licensing Act, or the University of Illinois Hospital Act; and
 - 4) Meet the applicable requirements of 89 Ill. Adm. Code 148.40(d).
- b) Encounter rate clinics must be presently participating in the Medical Assistance Program. Individual practitioners associated with such centers may apply for participation in the Medical Assistance Program in their individual capacities. In order to participate in the Healthy Moms/Healthy Kids Program, as described in Subpart G, encounter rate clinics shall be required to meet the additional participation requirements described in Section 140.924(a)(2)(B).
- e) ~~Psychiatric clinics must have the appropriate facilities and qualified professional staff to meet the recipient's needs in the specialized care they have been established to provide.~~
- e)c) Rural health clinics must be certified by Social Security Administration as meeting the requirements for Medicare participation.
- e)d) Federally Qualified Health Centers (FQHC):

- 1) Must be Health Centers which:
 - 1)a) receive a grant under Section 329, 330 or 340 of the Public Health Service Act; or
 - 2)b) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, are determined to meet the requirements for receiving such a grant.

- 2) In order to participate in the Healthy Moms/Healthy Kids Program, as described in Subpart G, FQHC's shall be required to meet the additional participation requirements described in Section 140.924(a)(2)(A).

f)e) Individual practitioners associated with such centers may apply for participation in the Medical Assistance Program in their individual capacities.

f) Healthy Moms/Healthy Kids Managed Care Clinics

- 1) Types of Clinics

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Section 140.461(f)(1) (continued)

Healthy Moms/Healthy Kids Managed Care Clinics are as follows:

- A) Certified Hospital Ambulatory Primary Care Centers (CHAPCC), which are hospital-based organized outpatient clinics, as described in subsection (a) above, meeting the participation, data and certification requirements described in subsections (f)(2) through (f)(5) below, which, through staff and supporting resources, provide ambulatory primary care to Medicaid children from birth through 20 years of age, and pregnant women in a non-emergency room setting. At least 50% of all staff physicians providing care in a CHAPCC must routinely provide obstetric, pediatric, internal medicine, or family practice care in the clinic setting, and at least 50% of patient visits to the CHAPCC must be for primary care.
- B) Certified Hospital Organized Satellite Clinics (CHOSC), which are clinics meeting the participation, data and certification requirements described in subsections (f)(2) through (f)(5) below, that are owned, operated, and/or managed by a hospital but do not qualify as hospital-based organized clinics, as described in subsection (a) above, because they are not located adjacent to or on the premises of the hospital or are not licensed under the Hospital Licensing Act or the University of Illinois Hospital Act. Through staff and supporting resources, these clinics provide ambulatory primary care in a non-emergency setting to Medicaid children from birth through 20 years of age, and to pregnant women. At least 50% of all staff physicians providing care in a CHOSC must routinely provide obstetric, pediatric, internal medicine, or family practice care in the clinic setting, and at least 50% of patient visits to the CHOSC must be for primary care. Primary care consists of basic health services provided by a physician or other qualified medical professional to maintain the day-to-day health status of a patient, without requiring the level of medical technology and specialized expertise necessary for the provision of secondary and tertiary care.
- C) Certified Obstetrical Ambulatory Care Centers (COBACC), which are hospital-based organized clinic entities, as described in subsection (a) above, meeting the participation, data and certification requirements described in subsections (f)(2) through (f)(5) below, which, through staff and supporting resources, provide primary care and specialty services to Medicaid-eligible

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Section 140.461(f)(1)(C) (continued)

Section 140.461(f)(2)(B)(i) (continued)

pregnant women, especially those determined to be non-compliant or at high risk, in an outpatient setting.

- D) Certified Pediatric Ambulatory Care Centers (CPACC), which are hospital-based organized clinic entities, as described in subsection (a) above, meeting the participation, data and certification requirements described in subsections (f)(2) through (f)(5) below, that, through staff and supporting resources, provide pediatric primary care and specialty services to Medicaid enrolled children with specialty needs, as described in Section 140.462(e)(3)(C), from birth through 20 years of age in an outpatient setting. Hospitals with CPACC's must also provide primary care for at least 1,500 children, not eligible for enrollment in the CPACC, as part of a CHAPCC, as described in subsection (f)(1)(A) above, a CHOSC, as described in subsection (f)(1)(B) above, or an encounter rate clinic, as described in section 140.461(b) above and Section 140.924(a)(2)(B). Hospitals unable to meet this volume requirement must agree to serve as a specialty referral site for another hospital operating a CPACC through a written agreement submitted to the Department.

2) General Participation Requirements

In addition to the Healthy Moms/Healthy Kids provider participation requirements described in Section 140.924(a)(1), the Healthy Moms/Healthy Kids managed care clinics identified in subsection (f)(1) above must:

- A) Provide managed care to clients, as described in Section 140.922(b)(1);
- B) Be operated by a disproportionate share hospital, as described in 89 Ill. Adm. Code 148.120, be staffed by board certified/eligible physicians who have hospital admitting and/or delivery privileges, be operated by a hospital in an organized corporate network of hospitals having a total of more than 1,000 staffed beds, and agree to provide care for a minimum of 100 Healthy Moms/Healthy Kids clients; or be a primary care teaching site of an organized academic department of:
- i) In the case of clinics described in subsections (f)(1)(A) and (f)(1)(B) above, a pediatric or family

practice residency program accredited by the American Accreditation Council for Graduate Medical Education or other published source of accrediting information.

- ii) In the case of clinics described in subsection (f)(1)(C) above, an obstetrical residency program accredited by the American Accreditation Council for Graduate Medical Education or other published source of accrediting information with at least 130 full-time equivalent residents or other published source of accrediting information.

- iii) In the case of clinics described in subsection (f)(1)(D) above, a pediatric or family practice residency program accredited by the American Accreditation Council for Graduate Medical Education or other published source of accrediting information with at least 130 full-time equivalent residents.

- C) Under the direction of a board certified/eligible physician who has hospital admitting and/or delivery privileges and provides direct supervision to residents practicing in the certified ambulatory site, provide:

- i) In the case of clinics described in subsections (f)(1)(A) and (f)(1)(B) above, primary care.
- ii) In the case of clinics described in subsection (f)(1)(C) above, obstetric and specialty services.
- iii) In the case of clinics described in subsection (f)(1)(D) above, primary care and specialty services.

- D) Maintain a formal, ongoing quality assurance program that meets the minimum standards of the Joint Commission on Accreditation of Health Care Organizations (JCAHO);

- E) Provide historical evidence of fiscal solvency and financial projections for the future, in a manner specified by the Department;

- F) Utilize a formal client tracking and care management system that affords timely maintenance of, access to, and continuity of medical records without compromising client confidentiality; and

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Section 140.461(f)(2) (continued)

- (c) In accordance with the terms of the Department's Healthy Moms/Healthy Kids program manual and provider agreement for the applicable Healthy Moms/Healthy Kids managed care clinic identified in subsection (f)(1) above, provide specific Healthy Moms/Healthy Kids client assignment capacity proposals to the Department and agree to accept site-specific enrollment and primary care practitioner responsibility for a specified minimum number of:
- i) In the case of clinics described in subsections (f)(1)(A) and (f)(1)(B) above, clients assigned by the Department or its agent.
 - ii) In the case of clinics described in subsection (f)(1)(C) above, high-risk and/or non-compliant pregnant women assigned by the Department or its agent.
 - iii) In the case of clinics described in subsection (f)(1)(D) above, children assigned by the Department or its agent.
- 3) Special Participation Requirements
- In addition to the Healthy Moms/Healthy Kids provider participation requirements described in Section 140.924(a)(1), and the general participation requirements described in subsection (f)(2) above, special participation requirements shall apply as follows:
- A) Clinics described in subsections (f)(1)(A) and (f)(1)(B) above must:
 - i) Serve a total population that includes at least 20% Medicaid and medically indigent clients;
 - ii) Perform a risk assessment on pregnant women assigned to them in order to determine if the woman is at high risk; and
 - iii) Provide or arrange for specialty services when needed by Healthy Moms/Healthy Kids clients.
 - B) Clinics described in subsection (f)(1)(C) must:
 - i) Be a distinct department of a hospital that also operates as a Level II or Level III perinatal center;

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- ii) Provide services to pregnant women demonstrating the need for extensive health care services due to complicated medical conditions placing them potentially at high risk of abnormal delivery, including substance abuse or addiction problems. Hospital clinics will not qualify to participate unless they provide both primary and specialty services to each Medicaid and Medicaid-eligible woman who receives services at the COBACC; in this capacity, COBACC's, as perinatal centers, shall also agree to accept assignment of pregnant women determined to be at high risk of abnormal delivery;
 - iii) Operate a designated 24-hour per day emergency referral site with a defined practice for the care of obstetric emergencies;
 - iv) Have an established program of services for the treatment of substance-abusing pregnant women;
 - v) Integrate an accredited obstetrical residency program with subspecialty residency programs to encourage future physicians to devote part of their professional services to disadvantaged and underserved high-risk pregnant women; and
 - vi) Operate organized ambulatory clinics for pregnant women that are easily accessible to the medically underserved.
- C) Clinics described in subsection (f)(1)(D) above must:
- i) Provide primary and specialty services for children demonstrating the need for extensive health care services due to a chronic condition as described in Section 140.462(e)(3)(C). CRACC's shall not enroll children who receive specialty services from the CPACC entity but receive primary care outside the CPACC, and do not have a diagnosed condition contained in, but not limited to, those listed in Section 140.462(e)(3)(C) requiring specialty services unless the child is the sibling of a CPACC-eligible or enrolled individual;
 - ii) Operate a designated 24-hour per day emergency referral site with a defined practice for the care of

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Section 140.461(f)(3)(C)(ii) (continued)

pediatric emergencies:

- iii) Provide access to necessary pediatric primary and specialty services within 24 hours after referral;
- iv) Be a distinct department of a Disproportionate Share Hospital (DSH), as described in 89 Ill. Adm. Code 148.120(a)(5);
- v) Integrate an accredited pediatric or family practice residency program with subspecialty residency programs to encourage future physicians to devote part of their professional services to disadvantaged and underserved children with specialty needs; and
- vi) Operate organized ambulatory clinics for children that are easily accessible to the medically underserved.

4) Data Requirements

The Healthy Moms/Healthy Kids managed care clinics described in subsection (f)(1) above shall be required to submit patient level historical data to the Department, which may include, but shall not be limited to historical data on the use of the hospital emergency room department.

5) Certification Requirements

Certification of qualifying status of a Healthy Moms/Healthy Kids managed care clinic identified in subsection (f)(1) above shall occur annually during the first two years of participation and every other year thereafter. In addition:

- A) The certification process shall consist of a review of the completed application and related materials to determine provisional certification status. Those centers submitting approved applications shall then be reviewed on-site by Department staff within 60 days after application approval. Final notification of certification status shall be rendered within 30 days after the site review, pending provider submittal of a written plan of correction for any deficiencies discovered during the entire application process.
- B) Entities interested in becoming a Healthy Moms/Healthy Kids

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Section 140.461(f)(5)(B) (continued)

managed care clinic must direct a written request for an application packet to the following address:

Managed Care Clinic Certification
Bureau of Hospital Services
Illinois Department of Public Aid
201 South Grand Avenue East, Concourse
Springfield, Illinois 62763-0001

- C) Certification status shall be suspended for Healthy Moms/Healthy Kids managed care clinics identified in subsection (f)(1) above that do not submit data to the Department, as required under subsection (f)(4) above, within 180 days after the Department's request for the submittal of such data.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 140.462 Covered Services in Clinics

- a) Payment shall be made to clinics for the following types of services when provided by, or under the direction of, a physician:

a) Hospital-based organized clinics:

- 1) With respect to those hospital-based organized clinics that qualify as Healthy Moms/Healthy Kids managed care clinics, as described in Section 140.461(f)(1), covered services are those described in subsection (e) below, as appropriate.

- 2) With respect to all other hospital-based organized clinics, covered services are those described in 89 Ill. Adm. Code 148.

b) Encounter rate clinics:

- 1) With respect to those encounter rate clinics that qualify as Healthy Moms/Healthy Kids providers, as described in Section 140.924(a)(2)(B), covered services are those described in Section 140.922.

- 2) With respect to all other encounter rate clinics, covered services are medical ~~Medica~~l services which provide for the continuous health care needs of persons who elect to use this type of service.

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Section 140.462(b) (continued)

- 2) ~~Psychiatric-clinics~~
- A) ~~Control-of-medication~~
- B) ~~Individual-therapy~~
- C) ~~Family-therapy~~
- D) ~~Group-therapy~~
- E) ~~Counseling~~
- F) ~~Electric-shock-treatment~~
- G) ~~Diagnostic-evaluation~~

3)c) Rural health clinics:

- A)1) Physician's Services, including covered services of nurse practitioners, nurse midwives and physician-supervised physician assistants.
- B)2) Medically-necessary services and supplies furnished as an incident to a physician's professional services.

4)d) Federally Qualified Health Centers:

- 1) With respect to those FQHC's that qualify as Healthy Moms/Healthy Kids providers, as described in Section 140.924(a)(2)(A), covered services are those described in Section 140.922.
- 2) With respect to all other FQHC's, covered services are the following services, when delivered in a clinic setting as described in 42 CFR 440.90 (1989):
 - A) Physician's services, including covered services of nurse midwives, nurse practitioners and physician-supervised physician assistants.
 - B) Medically-necessary services and supplies furnished by or under the direction of a physician or dentist within the scope of licensed practice, including:
 - 1) medical case management;

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Section 140.462(d)(2)(B) (continued)

- ii) laboratory services;
- iii) occupational therapy;
- iv) patient transportation;
- v) pharmacy services;
- vi) physical therapy;
- vii) podiatric services;
- viii) psychological services;
- ix) services required to be provided by Section 329.330 or 340 of the Public Health Service Act;
- x) speech and hearing services;
- xi) x-ray services;
- xii) health education;
- xiii) dental services; and
- xiv) nutrition services.

e) Healthy Moms/Healthy Kids Managed Care Clinics:

Payment shall be made to the Healthy Moms/Healthy Kids managed care clinics identified in Section 140.461(f)(1) for the following services when provided by, or under the direction of, a physician:

- 1) In the case of clinics described in Sections 140.461(f)(1)(A) and 140.461(f)(1)(B), primary care services delivered by the clinic which must include, but are not necessarily limited to:
 - A) Early, periodic, screening, diagnostic, and treatment (EPSDT) services as defined in Section 140.485;
 - B) Childhood risk assessments to determine potential need for mental health and substance abuse assessment and/or treatment;
 - C) Regular immunizations for the prevention of childhood diseases;

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Section 140.462(e)(1) (continued)

- D) Follow-up ambulatory medical care deemed necessary, recommended, or prescribed by a physician as a result of an EPSDT screening;
- E) Routine prenatal care, including risk assessment, for pregnant women; and
- F) Specialty care as medically needed.
- 2) In the case of clinics described in Section 140.461(f)(1)(C), primary care and specialty services delivered by the clinic must include, but are not necessarily limited to:
- A) Prenatal care, including risk assessment (one risk assessment per pregnancy);
- B) All ambulatory treatment services deemed medically necessary, recommended, or prescribed by a physician as the result of the assessment; and
- C) Services to pregnant women with diagnosed substance abuse or addiction problems.
- 3) In the case of clinics described in Section 140.461(f)(1)(D):
- A) Comprehensive medical and referral services.
- B) Primary care services, which must include, but are not necessarily limited to:
- i) early, periodic, screening, diagnostic, and treatment (EPSDT) services as defined in Section 140.485;
 - ii) regular immunizations for the prevention of childhood diseases; and
 - iii) follow-up ambulatory medical care deemed necessary, recommended, or prescribed by a physician as the result of an EPSDT screening.
- C) Pediatric specialty services which must include, at a minimum, necessary treatment for:
- i) asthma,
 - ii) congenital heart disease,

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Section 140.462(e)(3)(C) (continued)

- iii) diabetes, and
- iv) sickle cell anemia.

D) Ambulatory treatment for other medical conditions as specified in the center's certificate application and as approved by the Department.

(Source: Amended at 18 Ill. Reg. ____, effective February 28, 1994)

Section 140.463 Clinic Service Payment

a) Hospital-Based Organized Clinics

- 1) With respect to those hospital-based organized clinics that qualify as Healthy Moms/Healthy Kids managed care clinics, as described in Section 140.461(f)(1), payment shall be in accordance with Section 140.464.

- 2) With respect to all other hospital-based organized clinics, payment shall be in accordance with 89 Ill. Adm. Code 148.140.

a)b) Encounter Rate Clinic

- 1) Payment shall be made at the lesser of:

- 1)A) The clinic's approved all inclusive interim per encounter rate as of May 1, 1981; or

- 2)B) \$50.00 per encounter; or

- 3)C) the clinic charge to the general public.

- 2) Encounter rate clinics that qualify as Healthy Moms/Healthy Kids providers, as described in Section 140.924(a)(2)(B), shall receive a patient management fee, as described in Section 140.930(b), in addition to the reimbursement described in subsection (b)(1) above.

b)c) Federally Qualified Health Centers (FQHC):

- 1) Medical Encounter Rate

- A) Payment for services rendered after March 31, 1990, shall be made at an individual, all inclusive, prospective per

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Section 140.463(c)(1)(A) (continued)

diem rate calculated on the basis of the Department's encounter rate methodology and audited provider fiscal information reported on the Medicaid Freestanding Federally-Funded Health Center Worksheet (Health Care Financing Administration Form 242), as supplemented by FQHC Medicaid Supplemental Schedules A, B and C reflecting the actual costs of delivering encounter services as listed in Section 140.462 (a)(4).

- B) All cost reports will be audited by the Department to determine allowable costs for rate setting. The provider will be advised of any adjustments resulting from these audits.
- C) New rates effective each July 1 will be based on certified cost information from the provider's most recently audited fiscal year.
- D) Allowable costs will be updated to the mid point of the rate year by an inflation factor derived from published economic indices.
- E) Interim payment for covered services rendered by FQHCs enrolled as of March 31, 1990, for which no audited costs are available shall be made at the individual FQHC rate in effect on March 31, 1990, as established by the Department.
- F) Interim payment for covered services rendered by FQHCs enrolled between March 31, 1990 and January 1, 1991, shall be made at the higher of:
 - i) the provider's approved Medicare rate established by the designated federal intermediary for Rural Health Center or Federally Funded Health Center Services; or
 - ii) the 75th percentile of the statewide range of the Department's established encounter clinic rates (as defined in subsection (a) above) as of March 31, 1990.
- G) Payment shall be made at the interim rate to FQHCs enrolled before January 1, 1991, for covered services rendered from the later of the date of enrollment or April 1, 1990, until the certified date of provider receipt of the cost-based rate established by the Department for that provider.

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- H) When an individual cost-based rate has been established by the Department in accordance with the method described in subsection (b)(4)(A) (c)(1)(A) above, the Department shall reconcile interim payments made for covered services.
 - i) Rate retroactivity from April 1, 1990, will only apply to clinics enrolled as of March 31, 1990, which submit an application to the Public Health Service for Federally Qualified Health Center status by November 1, 1990, and are subsequently designated as federally qualified.
 - ii) If the cost-based rate is higher than the interim rate, the Department shall pay the provider the rate differential for each claim paid at the interim rate.
 - iii) If the cost-based rate is lower than the interim rate, the provider shall refund to the Department the rate differential for each claim paid at the interim rate, either by direct payment to the Department or as a credit applied against future service claims.
- I) Interim payment for covered services rendered by FQHCs enrolled on or after January 1, 1991, shall be made at the higher of:
 - i) the provider's approved Medicare rate established by the designated federal intermediary for Rural Health Centers and Federally Funded Health Centers Services; or
 - ii) the median of the statewide range of the Department's established cost-based FQHC rates in effect at the time of enrollment.
- J) Payment shall be made at the interim rate for Centers enrolled on or after January 1, 1991, for covered services rendered between the date of enrollment and 30 days after the date of Department receipt of the complete and correct cost report of the provider. Payment for covered medical services rendered by the provider 30 days after Department receipt of the provider's complete and correct cost report will be made at the rate determined on the basis of the submitted cost report and the Department's FQHC rate methodology.

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Section 140.463(c)(1) (continued)

K) If the FQHC has not submitted the required audited fiscal information on the forms specified in subsection (b)(1)(A) of this Section within 90 days of the certified date of receipt of the forms, the Department shall suspend payment for covered medical services until the required information is received by the Department, unless the enrolled Center has been in operation less than one year and has no audited cost history.

L) Enrolled FQHCs which have been in operation less than one year and have no audited cost history must submit required audited fiscal information reflecting the first six months of operation on the forms specified in subsection (b)(1)(A) of this Section, within 90 days after the later of the end of the sixth month of operation or the certified mail date of receipt of the forms. The rate calculated from these costs will be in effect for services rendered on and after the first day of the month following the month of receipt of the required fiscal information by the Department.

M) The Department will not process a claim for payment of FQHC services rendered after June 30, 1990, that does not indicate all individual medical services delivered during the encounter, by procedure code.

2) Dental Encounter Rate

A) Payment for dental services rendered after March 31, 1990, shall be made at an individual, all inclusive, prospective per diem rate calculated on the basis of the Department's encounter rate methodology and audited provider fiscal information reported on the Medicaid Freestanding Federally-Funded Health Center Worksheet (Health Care Financing Administration Form 242), as supplemented by FQHC Medicaid supplemental Schedules A, B, and C reflecting the actual costs of delivering dental services.

B) Direct costs related to operation of the clinic in order to provide allowable dental services will be reported on the cost report and used in the rate calculation process.

C) All cost reports will be audited by the Department to determine allowable costs for rate setting. The provider will be advised of any adjustments resulting from these audits.

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D) New rates effective each July 1 will be based on certified cost information from the provider's most recently audited fiscal year.

E) Allowable costs will be updated to the mid point of the rate year by an inflation factor derived from published economic indices.

F) Payment for covered dental services shall be made by the Department's prepaid dental service contractor.

G) When an individual cost-based rate has been established by the Department in accordance with the method described in subsection (b)(4)(A) (c)(2)(A) above, the Department's prepaid dental service contractor shall reconcile interim payments made for covered dental services.

i) Rate retroactivity will only apply to clinics enrolled as of March 31, 1990 which submit an application to the Public Health Service for Federally Qualified Health Center status by November 1, 1990, and are subsequently designated as federally qualified.

ii) If the cost-based rate is higher than the interim rate, the Department's prepaid dental service contractor shall pay the provider the rate differential for each claim paid at the interim rate.

iii) If the cost-based rate is lower than the interim rate, the provider shall refund to the Department the rate differential for each claim paid at the interim rate.

H) Interim payment for covered dental services rendered by FQHCs enrolled on or after January 1, 1991 shall be made at the median of the statewide range of the Department's established cost-based FQHC dental rates in effect at the time of enrollment.

I) Payment shall be made at the interim rate for Centers enrolled on or after January 1, 1991, for covered dental services rendered between the date of enrollment and 30 days after the date of the Department receipt of the complete and correct cost report of the provider. Payment for covered dental services rendered by the provider after 30 days of Department receipt of the provider's complete and correct cost report will be made at the rate determined

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Section 140.463(c)(2)(I) (continued)

on the basis of the submitted cost report and the Department's FQHC rate.

J) If the FQHC has not submitted the required audited fiscal information on the forms specified in subsection (b)(2)(A) (c)(2)(A) above within 90 days of the certified mail date of receipt of the forms, the Department's prepaid dental service contractor shall suspend payment for covered dental services until the required information is received by the Department, unless the enrolled Center has been in operation less than one year and has no audited cost history.

K) Enrolled FQHCs which have been in operation less than one year and have no audited cost history must submit required audited fiscal information reflecting the first six months of operation on the forms specified in subsection (b)(2)(A) (c)(2)(A) above within 90 days after the later of the end of the sixth month of operation or the certified date of receipt of the forms. The rate calculated from these costs will be in effect for dental services rendered on and after the first day of the month following the month of receipt of the required fiscal information by the Department.

3) Rate Appeals Process

A) All appeals of audit adjustments or rate determinations must be submitted in writing to the Department. Appeals submitted within 30 calendar days of the rate notification, if upheld, shall be made effective as of the beginning of the rate year. The effective date of all other upheld appeals shall be the first day of the month following the date the completed appeal was submitted. Appeals for any rate year must be filed before the close of the rate year.

B) To be accepted for review, the written appeal shall include:

- i) The current approved reimbursement rate, allowable costs, and the additional reimbursable costs sought through the appeal;
- ii) A clear, concise statement of the basis for the appeal;
- iii) A detailed statement of financial, statistical, and related information in support of the appeal, indicating the relationship between the additional

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Section 140.463(c)(3)(B)(iii) (continued)

reimbursable costs as submitted and the circumstances creating the need for increased reimbursement;

iv) A citation to any mandated or contractual requirement pertinent to the appeal; and

v) A statement by the provider's chief executive officer or financial officer that the application of the rate appeal and information contained in the vendor's reports, schedules, budgets, books, and records submitted are true and accurate.

C) Rate appeals may be considered for the following reasons:

i) Mechanical or clerical errors committed by the provider in reporting historical expenses used in the calculation of allowable costs.

ii) Mechanical or clerical errors committed by the Department in auditing historical expenses as reported and/or in calculating reimbursement rates.

iii) The Department and the provider have entered into a written agreement to amend, alter, or modify substantive programmatic or management procedures attendant to the delivery of services, which have a substantial impact upon the costs of service delivery.

iv) Substantial treatment service charges are required as a result of mandated regulatory charges.

v) Substantial changes in the physical plant are required as a result of mandated licensure requirements. In such instances, the provider must submit a plan of corrections for capital improvements approved by the licensing authority, along with the required cost information.

vi) State and/or Federal regulatory requirements have generated a substantial increase in allowable costs.

D) The Department shall rule on all appeals within 120 calendar days of receipt of the appeal except that, if additional information is required from the facility, the period shall be extended until such time as the information is provided.

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Section 140.463(c)(3) (continued)

- E) Appeals shall be submitted to the Department's Bureau of Comprehensive Health Services, 3rd floor Bloom Building, 201 South Grand Avenue East, Springfield, Illinois 62763.
- 4) FOHC's that qualify as Healthy Moms/Healthy Kids providers, as described in Section 140.924(a)(2)(A), shall receive a patient management fee, as described in Section 140.930(b), in addition to the reimbursement described in subsection (c)(1) above.

d) Healthy Moms/Healthy Kids Managed Care Clinics:

Payment shall be made in accordance with Section 140.464.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

Section 140.464 Healthy Moms/Healthy Kids Managed Care Clinics Psychiatric Clinics (Hospital-based)

~~Payment is as approved by the Department of Mental Health and Developmental Disabilities~~

Payment for services provided by Healthy Moms/Healthy Kids managed care clinics, as described in Section 140.461(f)(1), shall be as follows:

- a) In the case of clinics described in Sections 140.461(f)(1)(A), 140.461(f)(1)(B), and 140.461(f)(1)(C), payment shall be in accordance with Section 140.930(a)(1), except for:
- 1) Those services that meet the definition of the Hospital Ambulatory Care Program as described in 89 Ill. Adm. Code 148.140(a)(3), which shall be reimbursed in accordance with 89 Ill. Adm. Code 148.140(a)(3);
 - 2) End-stage renal disease treatment (ESRDT) services, which shall be reimbursed in accordance with 89 Ill. Adm. Code 148.140(b); and
 - 3) Those services provided by encounter rate hospitals, as described in 89 Ill. Adm. Code 148.140(c), which shall be reimbursed in accordance with 89 Ill. Adm. Code 148.140(c).
- b) In the case of clinics described in Section 140.461(f)(1)(D), payment shall be made as follows:
- 1) Reimbursement for Non-Assigned Clients

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Section 140.464(b)(1) (continued)

Covered services, as described in Section 140.462(e)(3), provided to Healthy Moms/Healthy Kids program clients that have not been assigned to the CPACC by the Department or its agent shall be reimbursed in accordance with subsection (a) above.

2) Reimbursement for Assigned Clients

Except as indicated in subsections (b)(3) through (b)(5) below, covered services, as described in Section 140.462(e)(3) shall be reimbursed on an all-inclusive encounter basis when rendered by the certified center or other certified CPACC site owned and operated by a common corporate entity, to those Healthy Moms/Healthy Kids clients assigned by the Department or its agent to that particular CPACC as the client's primary care practitioner. The all-inclusive encounter rate shall be calculated as follows:

- A) Newly-certified CPACC's shall be paid an encounter rate for covered services, as described in Section 140.462(e)(3), except as indicated in subsections (b)(3) through (b)(5) below, equal to the Department's established median encounter rate for Chicago Federally Qualified Health Centers (FOHC's), excluding those operated by a unit of city government.
- B) The rate shall be in effect for covered services, as described in Section 140.462(e)(3), except as indicated in subsections (b)(3) through (b)(5) below, rendered by the CPACC on or after the effective date of the CPACC's Healthy Moms/Healthy Kids provider agreement with the Department.
- 3) Ambulatory surgery and diagnostic procedures currently included in the Department's Hospital Ambulatory Care list, as described in 89 Ill. Adm. Code 148.140(a)(3), shall be reimbursed in accordance with 89 Ill. Adm. Code 148.140(a)(3).
- 4) Costs associated with pharmacy services provided by the CPACC, with the exception of those pharmacy service costs incurred in conjunction with the procedures described in subsection (b)(3) above, shall be reimbursed in accordance with the Department's established fee schedule for covered drug items.
- 5) In addition to the reimbursement described in subsections (b)(1) through (b)(4) above, CPACC's shall receive a patient management fee as described in Section 140.930(b).

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Section 140.464(b) (continued)

- 6) Payment shall be limited to not more than one encounter per client per day.
- 7) CRACC encounter rates shall be annually established effective each October 1, and will be entirely prospective. No year-end reconciliation will occur.

(Source: Section repealed, new Section added at 18 Ill. Reg. _____, effective February 28, 1994)

Section 140.485 Healthy Kids Program

a) Program Description

- 1) The Healthy Kids Program is the Early and Periodic Screening, Diagnosis and Treatment Program mandated by the Social Security Act (see 42 U.S.C. 1396a(43), 1396d(4)(B) (Supp.1987)). The goals of the program are to:

- A) improve the health status of Medicaid-eligible children ages birth through 20 years through the provision of preventive medical care and early diagnosis and treatment of conditions threatening the child's health; and
- B) reduce the long term costs of medical care to eligible children.

- 2) The Department strives to achieve these goals by offering the following services at no cost to an eligible child, except as may be limited by a spend down requirement:

- A) Periodic and interperiodic health, vision, hearing and dental screening services to meet the health care needs of children (see Section 140.488(a) through (d));
- B) immunizations against childhood diseases (see Section 140.488(e));
- C) diagnostic laboratory procedures as described in Section 140.488(f);
- D) further diagnosis or treatment necessary to correct or ameliorate defects and physical or mental illnesses or conditions which are discovered or determined to have

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Section 140.485(a)(2)(D) (continued)

increased in severity by a provider as the result of a periodic or interperiodic health, vision, hearing or dental screening;

- E) referral for dental care beginning at age two; and
- F) assistance in locating a provider, scheduling an appointment and in arranging transportation to and from the source of medical care.

- 3) The Department also strives to protect each eligible person's right to freedom of choice regarding participation and selection of a health care provider and the right to continuity of care.

- b) Eligibility. Services are available to those persons listed in Section 140.3, except that such persons must be under 21 years of age at the time of receiving such services.

- c) Provider Participation. Providers of Healthy Kids services must be duly licensed or certified according to applicable Federal or State law or rule and be enrolled in the Illinois Medical Assistance Program to provide one or more Healthy Kids Program services as authorized in Title XIX of the Social Security Act and the Illinois Medical Assistance Program State Plan (as set forth in Sections 140.11 thru 140.835).

d) Program Activities and Services

- 1) Informing Clients. The Department shall inform eligible persons in writing about the benefits of preventive health care, the services which are available, and procedures by which eligible persons may request and receive assistance in identifying an enrolled provider, scheduling an appointment or arranging transportation to and from the source of medical care. Effective July 1, 1990, the Department shall also notify Medicaid-eligible pregnant women, postpartum women during the six months after termination of pregnancy, women up to one year postpartum who are breastfeeding their infants or children below the age of five years of their potential eligibility for receiving services through the Special Supplemental Food Program for Women, Infants and Children which is administered by the Illinois Department of Public Health (IDPH). The informing of eligible persons shall be done as described in the Timeliness Standards contained in Section 140.487.

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Section 140.485(d) (continued)

- 2) Periodic Medical Screenings. The Department will pay for a series of periodic medical screenings scheduled from a person's birth through age 20. The Periodicity Schedule of screenings is contained in Section 140.488. The Department will pay for additional health screenings when necessary for:

- A) enrollment in school; or
- B) enrollment in a licensed day care program, including Headstart; or
- C) placement in a licensed child welfare facility, including a foster home, group home or child care institution; or
- D) attendance at a camping program; or
- E) participation in an organized athletic program; or
- F) enrollment in an early childhood education program recognized by the Illinois State Board of Education, or
- G) participation in a Women, Infant and Children (WIC) program; or
- H) is requested by a child's parent, guardian or custodian, or is determined to be necessary by social services, developmental, health, or educational personnel.

3) Dental Screenings

- A) Dental services shall include services for relief of pain and infections, restoration of teeth, and maintenance of dental health, including instruction in self care oral hygiene procedures.
- B) Eligible persons shall be referred for dental screenings beginning at age two if the person is not in the continuing care of an enrolled dental provider, except that a child younger than age two years may be referred for dental services when any health screening indicates the need for dental services.
- C) The periodicity schedule for dental screening services is contained in Section 140.488. The Department will pay for one dental screening per age period unless a second screening is medically necessary.

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Section 140.485(d) (continued)

4) Vision Screening

- A) The Department will pay for vision screening services, and diagnosis and treatment for defects in vision, including glasses.
- B) The periodicity schedule for vision screenings is contained in Section 140.488. The Department will pay for one vision screening per age period, except when a second screening is determined to be medically necessary.
- 5) Hearing Screening. The Department will pay for hearing screenings and diagnosis and treatment for defects in hearing, including hearing aids. The periodicity schedule for hearing screenings is contained in Section 140.488. The Department will pay for one hearing screening per age period, except when a second screening is determined to be medically necessary.
- 6) Immunizations. The Department will pay for the immunization of eligible children against childhood diseases. The list of covered immunizations is contained in Section 140.488(b).

7) Diagnostic Procedures

A) Lead Screening

- i) The Department requires that lead screening shall be performed in compliance with the "Lead Poisoning Prevention Act, Public Act 87-175", as amended, effective January 1, 1992. Children between the ages of six months to six years should be screened for lead poisoning at priority intervals. Screenings and medical follow up shall be performed in accordance with the "Guidelines for the Detection and Management of Lead Poisoning for Physicians and Health Care Providers", published by the Illinois Department of Public Health. These guidelines recommend that those children at highest risk be screened on a regular basis. High risk environmental situations include housing built before 1978, housing which is being renovated or remodeled, or which is in deteriorating condition. Children six years and older shall also be screened, where medically indicated or appropriate.

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Section 140.485(d)(7)(A) (continued)

- ii) The Department will pay for lead screening as indicated in subsection (d)(7)(A)(i) above or as required for admission by a day care center, day care home, preschool, nursery school, kindergarten, or other child care facility or educational facility licensed by the State.

- iii) The Department will pay for epidemiological study of the child's living environment when the child has been diagnosed as having an elevated blood lead level for the purpose of identifying the source of lead exposure.

- B) The Department will pay for the administration of all other medically necessary diagnostic procedures performed during or as the result of medical screenings.

- 8) Treatment. The Department shall pay for necessary medical care (see Section 140.2), diagnostic services, treatment or other measures medically necessary (e.g., medical equipment and supplies) to correct or ameliorate defects, and physical and mental illnesses and conditions which are discovered or determined to have increased in severity by medical, vision, hearing or dental screening services.

- 9) Assistance Services. The Department shall, upon request, provide assistance to eligible children and their parent, guardian or custodian to locate a provider, schedule an appointment or arrange transportation to and from the source of medical care.

- 10) Timeliness Standards. The Timeliness Standards in Section 140.487 will govern the completion of required activities and services.

e) Reimbursement to Providers

- 1) Fee-for-service. Provider's enrolled in the Healthy Moms/Healthy Kids program, as described in Subpart G, will receive enhanced rates for certain services as described in Section 140.930(a)(1). Payment will be made at the provider's usual and customary charges or the established Department rate(s) (see Section 140.400), whichever is less, for providers not enrolled in the Healthy Moms/Healthy Kids program. Reimbursement for the administration of immunizations administered to an eligible person will be made at rates

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Section 140.485(e)(1) (continued)

established by the Department. The provider will receive replacement vaccines as explained in subsection (e)(3) below, in one of two ways at the choice of the provider:

- A) The provider will receive payment for the cost of the vaccine and administration at rates established by the Department; or
- B) The provider will receive payment for administering the immunization at a rate established by the Department and receive replacement vaccine(s) as explained in subsection (e)(3).

- 2) Claims. Claims for reimbursement shall be submitted on the form and in a manner specified by the Department.

- 3) Vaccine Replacement Program. When a provider administers an immunization to an eligible child, request either verbally or in writing to receive replacement vaccine as part of reimbursement as discussed in subsection (e)(1); the vaccine(s) are replaced to the provider through the Vaccine Replacement program which is administered jointly by the Department and the IDPH. Providers must be annually certified for participation in the Vaccine Replacement Program by IDPH before receiving replacement vaccines. Information on the Vaccine Replacement Program and certification procedures (set forth at 42 CFR 51b) may be obtained by contacting:

Immunization Vaccine Replacement Program
Illinois Department of Public Health
525 West Jefferson Street
Springfield, Illinois 62761

- f) Limitations on Services. Services under the Healthy Kids Program shall only be available to persons in the age groups from birth through age 20. Coverage of and payments for services shall be consistent with the requirements of Section 1905 of the Social Security Act (42 U.S.C. 1396d) as it relates to the Early and Periodic Screening, Diagnosis and Treatment Program.

- g) Record Requirements. The provider shall comply with record requirements as set forth in Section 140.28.

(Source: Amended at 18 Ill. Reg. ____, effective February 28, 1994)

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SUBPART E: GROUP CARE

Section 140.523 Bed Reserves

a) Nursing Facilities

1) All bed reserves must:

1A) be authorized by a physician (and in the case of hospitalization, the physician must anticipate that the hospitalization will not exceed 10 ten days);

2B) have post payment approval from the Bureau of Long Term Quality Care nurse based on satisfying the requirements of this Section;

3C) be limited to ~~recipients~~ residents who desire to return to the same facility; and

4D) be limited to facilities having a 93 percent or higher occupancy level. The occupancy level shall be calculated including both payable and non-payable (non-payable defined as those residents that have transitioned from the maximum days allowed for payable bed reserve to non-payable bed reserve status) bedhold days as occupied beds.

b2) Payment may be approved for hospitalization for a period not to exceed 10 ten days per hospital stay. The day the ~~recipient~~ resident is transferred to the hospital is the first day of the reserve bed period.

e3) Payment may be approved for home visits which have been indicated by a physician as therapeutically beneficial. In such instances, bed reserve is limited to 7 seven consecutive days in a billing month or 10 ten non-consecutive days in a billing month. The day after the ~~recipient~~ resident leaves the facility is the first day of the reserve bed period. Home visits may be extended with the approval of the Department.

e4) The Bureau of Long Term Quality Care nurse will approve ongoing therapeutic home visits based on the physician's standing orders for the individual. Standing orders for therapeutic home visits limited to 10 ten days per month are valid for a period not exceeding six months.

e5) Payment for approved bed reserves is a daily rate at 75% of an individual's current Medicaid per diem.

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Section 140.523(a) (continued)

f6) In no facility may the number of vacant beds be less than the number of beds identified for ~~patients~~ residents having an approved bed reserve. The number of vacant beds in the facility must be equal to or greater than the number of ~~patients~~ residents allowed bed reserve.

b) ICF/MR Facilities (including ICF/DD and SNF/PED facilities)

1) All bed reserves must:

A) be authorized by the interdisciplinary team (IDT) referenced in 89 Ill. Adm. Code 144.100 (a) through (c);

B) have post payment approval from the Bureau of Disability Services;

C) be limited to residents who desire to return to the same facility.

2) There is no minimum occupancy level ICF/MR facilities must meet for receiving bed reserve payments.

3) In no facility may the number of vacant beds be less than the number of beds identified for residents having an approved bed reserve. The number of vacant beds in the facility must be equal to or greater than the number of residents allowed bed reserve.

4) Payment may be approved for hospitalization for a period not to exceed 45 consecutive days. The day the resident is transferred to the hospital is the first day of the reserve bed period. Payment for approved bed reserves for hospitalization is a daily rate at:

A) 100% of a facility's current Medicaid per diem for the first ten days of an admission to a hospital;

B) 75% of a facility's current Medicaid per diem for days 11 through 30 of the admission;

C) 50% of a facility's current Medicaid per diem for days 31 to 45 of the admission.

5) Payment may be approved for therapeutic visits which have been indicated by the IDT as therapeutically beneficial. There is no limitation on the bed reserve days for such approved therapeutic visits. The day after the resident leaves the facility is the

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Section 140.523(b)(5) (continued)

first day of the bed reserve period. Payment for approved bed reserves for therapeutic visits is a daily rate at:

- A) 100% of a facility's current Medicaid per diem for a period not to exceed ten days per State fiscal year;
- B) 75% of a facility's current Medicaid per diem for a period which exceeds ten days per State fiscal year.

(Source: Amended at 18 Ill. Reg. ____, effective February 28, 1994.)

**SUBPART G: REIMBURSEMENT FOR NURSING-CARETAKING FACILITIES
HEALTHY MOMS/HEALTHY KIDS PROGRAM**

Section 140.920 General Description

- a) The Healthy Moms/Healthy Kids Program is a primary health care program coupled with case management services for Medicaid enrolled pregnant women and children. The program is designed to ensure access to quality health care services statewide by linking pregnant women and children through age 20 with a primary care provider or an HMO who will be responsible for providing primary care and arranging, or in some areas of the State, authorizing specialty care. Although the Healthy Moms/Healthy Kids Program is available on a statewide basis, certain components of the program, as described in subsection (b)(1) below, will not initially be implemented on a statewide basis.

b) Program Components

1) Managed Care Component

The Healthy Moms/Healthy Kids Program shall include a managed care component, as described in Section 140.922(b), which shall be in place for clients who reside in a zip code served by a local public aid office located in the City of Chicago. The managed care component requires all pregnant women and children who fall in certain categories of Medical Assistance, as described in Section 140.926(a)(1), to choose a Primary Care Provider (PCP) from the listing of provider types described in Section 140.922(b)(3). Under the managed care component, the selected PCP is responsible for locating, coordinating and monitoring all health care and utilization of non-emergency services, in accordance with Section 140.922(b)(3).

2) Case Management Component

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Section 140.920(b)(2) (continued)

The Healthy Moms/Healthy Kids Program shall also include a case management component which shall be in place statewide. Under the case management component, pregnant women and children under the age of six will be provided with case management services, as described in Section 140.922(c), by a community-based case management agency that will be responsible for assisting the client in accessing health care and support services necessary to comply with their physicians' recommendations.

3) Enhanced Reimbursement Component

The Healthy Moms/Healthy Kids Program is designed to increase provider participation through special incentives for providers. These include increased payment rates for selected services, as described in Section 140.930, and expedited payment. To participate in the program, providers must meet specific participation requirements, as described in Section 140.924, and sign a Healthy Moms/Healthy Kids provider agreement, in addition to being enrolled as a Medicaid Provider.

(Source: Added at 18 Ill. Reg. ____, effective February 28, 1994.)

Section 140.922 Covered Services

a) Medical Services

All services covered under the Illinois Medical Assistance Program shall be available to recipients participating in the Healthy Moms/Healthy Kids Program.

b) Primary Care Physician Services

1) Geographic areas covered by the Managed Care Component

In areas covered by the managed care component, as described in Section 140.928(a)(1), clients will be required to select a Primary Care Provider (PCP). In these areas, Medicaid enrolled pregnant women and children under age 21 must choose a single primary care provider (PCP). This may be a regular doctor, a Department approved clinic or a Health Maintenance Organization (HMO), as described in subsection (b)(3) below. For those choosing a physician or clinic, all primary health care will be provided by the PCP. The PCP may authorize another provider to render services outside the PCP's scope of practice. Clients

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Section 140.922(b)(1) (continued)

eligible for case management services, as described in subsection (c) below, will be assigned to the case management agency designated to work with their chosen PCP.

2) Clients will be enrolled with their chosen physician or clinic provider indefinitely, with an option to make a different choice every six months. Providers will receive a monthly patient management fee for each client enrolled with them. Physicians may participate independently or as part of an approved clinic. Through the managed care component, clients are encouraged to establish a continuing relationship with a single provider.

3) The PCP is responsible for locating, coordinating and monitoring all health care and utilization of non-emergency services. The PCP must provide primary care directly and must authorize all referrals to specialists as cited in Section 140.932. Participants may select a PCP from one of the following provider types:

A) Primary Care physicians who meet certain program criteria as cited in Section 140.924(a)(1);

B) Federally Qualified Health Centers (FQHC), as described in Section 140.461(d), that meet the additional requirements described in Section 140.924(a)(2)(A);

C) Encounter Rate Clinics, as described in Section 140.461(b), that meet the additional requirements described in Section 140.924(a)(2)(B); and

D) Healthy Moms/Healthy Kids Managed Care Clinics, as described in Section 140.461(f).

4) Clients living outside an area with a managed care component will not be enrolled with a single provider as described above. Unless enrolled with a Health Maintenance Organization (HMO), Medicaid clients will not be required to receive primary health care services from a single provider but will be encouraged to do so. Providers will refer clients for needed specialty care but will not be required to authorize those services. Providers in areas without the managed care component will not receive the monthly patient management fee but will receive the same enhanced rates provided to those who serve in areas where the Managed Care Program has been implemented.

c) Case Management Services

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Section 140.922(c) (continued)

Case management for Medicaid recipients is defined as a function necessary for the proper and efficient operation of the Medicaid State Plan. Case management services will be provided to pregnant women and children under six statewide. Services include but are not limited to:

- 1) Coordination of Medicaid covered services;
- 2) Arranging for transportation to and from a source of medical care;
- 3) Client education regarding Medicaid covered services, the benefits of preventive medical and dental care, and how to efficiently utilize the Medicaid system and access services;
- 4) Prenatal education or health education;
- 5) Referral for services such as Women, Infants and Children (WIC);
- 6) Assistance to ensure client compliance with services prescribed/recommended by the PCP (substance abuse treatment, Early Intervention services, psychiatric services/mental health, specialty care); and
- 7) Outreach and case finding.

(Source: Added at 18 Ill. Reg. _____, effective February 28, 1994)

Section 140.924 Provider Participation Requirements

a) Primary Care Providers

1) Basic Requirements

Healthy Moms/Healthy Kids providers shall meet the qualifications (see Section 140.12) as are applicable for all medical providers under the Illinois Medical Assistance Program, and shall:

- A) maintain hospital admitting privileges;
- B) maintain delivery privileges if providing care to pregnant women;

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Section 140.924(a)(1) (Continued)

- C) be enrolled and in good standing with the Medical Assistance Program; and
- D) complete a Primary Care Provider Agreement in which they agree to:
- i) provide periodic health screening (EPSDT), including age appropriate immunizations, and primary pediatric care as needed for children served in their practice, consistent with guidelines published by the American Academy of Pediatrics or American Academy of Family Physicians;
 - ii) provide obstetrical care and delivery services as appropriate for pregnant women served through their practice, consistent with guidelines published by the American College of Obstetricians and Gynecologists or the American Academy of Family Physicians;
 - iii) provide risk assessments for pregnant women and/or children;
 - iv) provide medical care coordination including arranging for diagnostic consultation and specialty care;
 - v) communicate with the case management entity;
 - vi) maintain 24-hour telephone coverage for assessment and consultation; and
 - vii) provide equal access to quality medical care for assigned clients.

2) Special Requirements

In addition to the basic requirements described in subsection (a)(1) above, the following Healthy Moms/Healthy Kids providers shall be required to meet additional requirements as specified below:

- A) Federally Qualified Health Centers (FQHC) shall be required to:
- 1) Meet the qualifications for a FQHC, as described in Section 140.461(d);

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Section 140.924(a)(2)(A) (Continued)

- ii) Provide managed care to clients, as described in Section 140.922(b)(1); and
 - iii) Provide specific Healthy Moms/Healthy Kids client assignment capacity proposals to the Department and agree to accept site-specific enrollment and primary care practitioner responsibility for a specified minimum number of clients assigned by the Department or its agent in accordance with the terms of the Department's Healthy Moms/Healthy Kids Manual and provider agreement for FQHCs.
- B) Encounter Rate Clinics shall be required to meet the following additional requirements:
- i) Meet the qualifications for an encounter rate clinic, as described in Section 140.461(d);
 - ii) Be owned, operated, managed, or staffed by a hospital that also operates a Healthy Moms/Healthy Kids managed care clinic, as described in Section 140.461(f), or be located in a county with a population exceeding 3,000,000 that is part of an organized clinic system consisting of 15 or more individual practice locations, of which at least 12 are Federally Qualified Health Centers, as defined in Section 140.461(d).
 - iii) Provide managed care to clients, as described in Section 140.922(b)(1); and
 - iv) Provide specific Healthy Moms/Healthy Kids client assignment capacity proposals to the Department and agree to accept site-specific enrollment and primary care practitioner responsibility for a specified minimum number of clients assigned by the Department or its agent in accordance with the terms of the Department's Healthy Moms/Healthy Kids Manual and provider agreement for encounter rate clinics.
- C) Healthy Moms/Healthy Kids Managed Care Clinics shall be required to meet the applicable requirements described in Section 140.461(f).

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Section 140.924(a) (Continued)

3) The Department will consider requests from physicians who are unable to meet the hospital admitting privileges criteria for enrollment in the Healthy Moms/Healthy Kids Program if the physician has executed a formal agreement with another physician to accept referrals for hospital admissions. Requests will also be considered from physicians who do not have delivery privileges but wish to provide obstetrical care. The request will be reviewed by members of the State Medical Advisory Committee and a recommendation made by that body as to whether the physician should be enrolled as a PCP into the Program. At the discretion of the Committee, the requesting physician may be asked to appear for an interview and/or an on-site visit may be made by either a member of the Committee or a Department assigned physician consultant. For consideration to be given, the requesting physician must submit the following information and supporting documentation in a format specified by the Department which provides the following:

- A) Complete name, mailing address, Illinois practice license number and Medicaid provider number, if any;
 - B) Declared practice specialty;
 - C) Listing of all practice locations;
 - D) Name and location of hospitals applied to for admitting privileges;
 - E) Status of each request, i.e., pending or closed (if closed, a reason must be given by the hospital for not granting privileges);
 - F) If application has never been made, a statement explaining why;
 - G) Name of physician with whom a formal agreement has been effected;
 - H) Illinois license number of Medicaid enrolled physician with hospital admitting privileges and name of hospitals where admitting privileges are in effect; and
 - I) Copy of formal agreement.
- 4) The request is to be dated by the provider and forwarded to the

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Section 140.924(a)(4) (Continued)

Illinois Department of Public Aid, Provider Participation Unit,
P.O. Box 19114, Springfield, Illinois 62794-9114.

b) Case Management Providers

Case management providers' qualifications shall be in accordance with 77 Ill. Adm. Code 630, Subpart A. Case management will be provided to ensure access to medical care and better compliance with medical recommendations.

(Source: Added at 18 Ill. Reg. ____, effective February 28, 1994.)

Section 140.926 Client Eligibility

a) Geographic Areas Covered by the Managed Care Component

1) Clients Eligible for Services

In the areas covered by the managed care component, as described in Sections 140.928(a)(1), the Healthy Moms/Healthy Kids Program is limited to pregnant women and children age 20 and under whether receiving cash grants or as recipients of medical assistance only. Included in those covered categories are:

- A) AFDC - including cases which were cancelled due to earned income which qualify for up to 12 months of Medicaid coverage following cancellation;
- B) AFDC MANG - Medical Assistance, no grant, for pregnant women and children through age 20 with countable family income no greater than the MANG income standard;
- C) MANG (P) - Medical Assistance, no grant for pregnant women and children age five and under meeting the Omnibus Reconciliation Act (OBRA) requirements with countable family income to 133% of the federal poverty level;
- D) MANG (P) - Medical Assistance, no grant for children older than five and born after October 1, 1983 who meet the Omnibus Reconciliation Act (OBRA) requirements and have countable family income to 100% of the federal poverty level;
- E) AABD - blind or disabled pregnant women or children through the age of 20 who do not reside in long term care

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Section 140.926(a)(1)(E) (continued)

facilities:

- F) AABD - Medical Assistance, no grant, for pregnant women and children through age 20 with countable family income no greater than the MANG income standard who do not reside in long term care facilities;
- G) General Assistance - children through the age of 17;
- H) Medicaid Presumptively Eligible women (MPE); and
- I) Children who are wards of DCFS in foster care or other eligible substitute care settings.

2) Clients Exempt from Participation

Exempt from participation in the Healthy Moms/Healthy Kids Program will be those categorically eligible recipients who:

- A) are residing in a nursing facility or ICF/MR;
- B) have an eligibility that is only retroactive;
- C) elect to enroll in an HMO;
- D) are spend-down cases, excluding MANG(P); or
- E) are group care cases, model waiver children and DMHDD clients in residential facilities.

b) Geographic Areas Not Covered by the Managed Care Component

In areas not covered by the managed care component, all clients, regardless of eligibility category, who do not reside in a long term nursing facility or ICF/MR and who meet the following requirements, are covered under the Healthy Moms/Healthy Kids Program:

- 1) Pregnant women;
- 2) Children under age 21.

(Source: Added at 18 Ill. Reg. _____, effective February 28, 1994)

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NOTICE OF ADOPTED AMENDMENTS

Section 140.928 Client Enrollment and Program Components

The Healthy Moms/Healthy Kids Program enrollment and Program components are described below:

a) Areas Covered by the Managed Care Component

- 1) Medicaid enrolled pregnant women and children under age 21 who are served by a Local Public Aid Office located in the City of Chicago must participate in the Healthy Moms/Healthy Kids managed care component by choosing a primary care provider for each qualified family member or by enrolling with a Health Maintenance Organization (HMO).

2) Enrollment and Selection

- A) The enrollment and selection process for new applicants takes place at the Local Public Aid Office. At the conclusion of the screening interview, potential eligibles will be referred to a client education representative. During this face to face contact, the client will be presented with a description of the managed care options and asked to choose a PCP. The client representative will record the selection when an individual physician or clinic is chosen, or refer the client to an HMO representative when that is designated as the managed care choice. If the recipient is unable to choose a provider or the recipient's choice is not a suitable provider, a random choice of a Healthy Moms/Healthy Kids PCP or HMO will be made on the individual's behalf by the Department's agent. This assignment will be based on the recipient's age and sex, whatever is known of the recipient's medical condition and usual source of care, and the appropriate PCPs in the recipient's service area who have open slots for participants. The recipient and the chosen PCP will be informed of the intended assignment. Providers of obstetric care must agree to accept the assignment of a pregnant woman. However, the assignment cannot be refused on grounds that would be considered discriminatory.

- B) The assignment will take effect when so indicated on the next regularly-issued Medicaid card.

- C) Once a recipient has been enrolled in the Healthy Moms/Healthy Kids Program, the individual will remain in the program as long as he or she retains Medicaid eligibility, unless the participant is disenrolled when the waiver's eligibility requirements are no longer met, such

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Section 140.928(a)(2)(C) (continued)

as when the recipient is institutionalized in a nursing facility or ICF/MR, or moves to a nonparticipating geographic area.

- 3) All primary health care is to be provided by the primary care provider (PCP). Services outside the provider's scope of practice will be arranged and authorized by the primary care provider. In order for the non-PCP to receive enhanced rates for the services described in Section 140.922(b)(3)(A) when providing services outside the PCP's scope of service, the services must be authorized as described in Section 140.922(a).
- 4) Clients will be enrolled with an option to change without cause at six month intervals or with cause at any time. Cause shall exist in the following circumstances:
 - A) The client moves but the PCP continues to reside in the waiver area;
 - B) The PCP moves but the client continues to reside in the waiver area;
 - C) The client believes that the client's medical needs can be managed more effectively by a different provider;
 - D) The relationship between the client and the primary care provider is not mutually acceptable;
 - E) The primary care provider is inaccessible to the client or does not make 24-hour per day, seven days per week coverage available to the client;
 - F) The primary care provider and the client have a language barrier or other structural impediment to service;
 - G) The client alleges inappropriate behavior on the part of the primary care provider; or
 - H) The client was randomly assigned pursuant to Section 140.928(a)(2)(A).

- 5) The Department has contracted with an independent organization to assist in the operational function of this component of the Healthy Moms/Healthy Kids Program. The independent contractor will be responsible for providing program assistants at each local Public Aid office located in Chicago to educate clients

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Section 140.928(a)(5) (continued)

about the health delivery system options available to them under the Program and enroll them with their chosen primary care provider.

- 6) The independent organization will also assist providers in locating needed specialty care, administering a network of organizations performing supportive case management, operating a data system for client tracking purposes and operating a hotline to assist providers in obtaining needed information.
- 7) The independent organization will also authorize payment to the PCP when the PCP refers the client to another provider for specialty care.

b) Areas Not Covered by the Managed Care Component

Clients will not be enrolled with providers as described in subsection (a) above. Unless enrolled with a Health Maintenance Organization, downstate clients will not be required to receive primary health care services from a single provider, but will be encouraged to do so. Healthy Moms/Healthy Kids providers serving clients who live outside Chicago will be required to provide or refer their clients for needed specialty care but will not be required to authorize those services.

(Source: Added at 18 Ill. Reg. ____, effective February 28, 1994)

Section 140.930 Reimbursement

a) Reimbursement Rates for Healthy Moms/Healthy Kids Providers

- 1) Participating providers described in Section 140.922(b)(3)(A) that meet the criteria specified in 140.924(a)(1) will receive enhanced rates for certain medical services specified in Table M of this Part. The enhanced rates are effective for services provided on or after April 1, 1993.
- 2) Participating FQHC's, as described in Sections 140.922(b)(3)(B) and 140.461(d), that meet the criteria specified in 140.924(a)(2)(A), shall be reimbursed in accordance with Section 140.463(c) for covered services provided to a Healthy Moms/Healthy Kids Program participant, as described in Section 140.922.

Section 140.930(a) (continued)

- 3) Participating encounter rate clinics, as described in Sections 140.922(b)(3)(C) and 140.461(b), that meet the criteria specified in 140.924(a)(2)(B), shall be reimbursed in accordance with Section 140.463(b) for covered services provided to a Healthy Moms/Healthy Kids Program participant, as described in Section 140.922.
- 4) Participating Healthy Moms/Healthy Kids managed care clinics, as described in Sections 140.924(b)(3)(D) and 140.461(f), shall be reimbursed in accordance with Section 140.464 for covered services provided to a Healthy Moms/Healthy Kids Program participant, as described in Section 140.462(e).

b) Patient Management Fee

Participating providers who serve Medicaid enrolled pregnant women and children under age 21 who are covered under the managed care component will receive a monthly patient management fee for each client enrolled with them.

c) Case Management Services

Providers of case management services will receive monthly payments. The payments will be prorated based upon an annual amount per case. A higher rate will be paid to the case management agency for case managing a family that contains a pregnant woman or child under age one.

(Source: Added at 18 Ill. Reg. —, effective February 28, 1994)

Section 140.932 Payment Authorization for Referrals

- a) In the areas covered by the managed care component the PCP is required to provide primary care directly and must authorize referrals when the PCP determines that the client requires medical care outside his scope of practice. The PCP is required to make referral appointments. The PCP must notify the independent contractor that payment is authorized. Payments will be made to providers other than the PCP when a valid authorization number is reported on the claim form. Physicians practicing the same specialty in a single group can receive payment for services rendered to non-assigned clients by identifying the client's PCP as the referring practitioner, by name and Medicaid provider number, on the claim for payment.

Section 140.932 (continued)

- b) The following services DO NOT require a payment authorization number for billing purposes:

- 1) Hospital emergency room services;
- 2) Coverage by another physician as part of 24-hour a day, seven days a week coverage;
- 3) Family planning services;
- 4) Preventive services for children, including:
 - A) hearing screening;
 - B) vision screening;
 - C) immunizations; and
 - D) lead toxicity screening and epidemiological survey;
- 5) All diagnostic and clinical tests that are medically necessary;
- 6) Pharmacy services; or
- 7) Early intervention services for young children, such as:
 - A) speech therapy;
 - B) physical therapy; or
 - C) occupational therapy.

(Source: Added at 18 Ill. Reg. —, effective February 28, 1994)

Section 140.932 Enhanced Rates for Healthy Moms/Healthy Kids Provider Services

- a) In accordance with Sections 140.464 and 140.930(a), certain providers who serve women will receive enhanced reimbursement rates for the following services:

CODE	DESCRIPTION
W7359	Prenatal risk assessment

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NOTICE OF ADOPTED AMENDMENTS

Section 140. TABLE M(a) (continued)

CODE	DESCRIPTION
59410	Vaginal delivery
59515	C-section delivery

b) In accordance with Sections 140.464 and 140.930(a), certain providers who serve children under age 21 will receive enhanced reimbursement rates for the following services:

CODE	DESCRIPTION
W7018	Healthy Kids screening-Chicago/Downstate
W7360	Risk assessment, child referred for mental health assessment/services
W7361	Risk assessment, for mental health services, child, no referral

CODE	DESCRIPTION
W7362	Risk assessment, child referred for substance abuse assessment/treatment
W7363	Risk assessment for substance abuse, child, no referral
99201	Office visit - new patient - brief
99202	Office visit - new patient - limited
99203	Office visit - new patient - intermediate
99204	Office visit - new patient - extended
99205	Office visit - new patient - comprehensive
99211	Office visit - established patient - brief
99212	Office visit - established patient - limited
99213	Office visit - established patient - intermediate
99214	Office visit - established patient - extended
99215	Office visit - established patient - comprehensive

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Section 140. TABLE M (continued)

c) All other visits and services billed under valid CPT-4 procedure codes will be reimbursed at January 1, 1993, rates.

(Source: Added at 18 Ill. Reg. _____, effective February 28, 1994)

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

- 1) Heading of the Part: Related Program Provisions
- 2) Code Citation: 89 Ill. Adm. Code 117
- 3) Section Number: 117.10
Adopted Action: Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Public Act 88-412
- 5) Effective Date of Amendments: February 28, 1994
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Do these Amendments contain incorporations by reference? No
- 8) Date Filed in Agency's Principal Office: February 28, 1994
- 9) Notice of Proposal Published in Illinois Register:
December 10, 1993 (17 Ill. Reg. 21158)
- 10) Has JCAR issued a Statement of Objections to these Adopted Amendments? No
- 11) Differences between proposal and final version:
Changes in the statutory citations in Section 117.10(b)(3)(B) and (C) and in the Authority Note have been made to comply with recommendations of the Administrative Code Division.
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes
- 13) Will these Amendments replace Emergency Amendments currently in effect? No
- 14) Are there any Amendments pending on this Part? Yes

- | Sections | Proposed Action | Illinois Register Citation |
|----------|-----------------|--|
| 117.54 | Amendment | December 27, 1993 (17 Ill. Reg. 22007) |
- 15) Summary and Purpose of Amendments: These amendments implement the provisions of Public Act 88-412 by adding substance abuse as an additional circumstance for assigning a protective payee. Under these amendments, a protective payment plan will be initiated by the Department when substance abuse by the caretaker relative is identified and another family member or

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NOTICE OF ADOPTED AMENDMENTS

friend is ensuring that the family's needs are being met.

The problem of substance abuse is of great concern to members of the child welfare community. When an AFDC client is experiencing problems with substance abuse (such as drugs or alcohol), the AFDC payments made to that caretaker relative may not always be used in the best interests of the children. In these situations, there may be another family member or close family friend, other than the caretaker relative, who is ensuring that the family's needs are being met (such as paying rent and purchasing food). The family member or friend actually addressing the family's needs may be better able to accept responsibility for receipt of the family's assistance benefits and to use these benefits in the best way possible to ensure that the children's needs are met.

Since the care and supervision of the children and management of the family's resources must be handled directly on a day by day basis to ensure that assistance benefits are not used to subsidize substance abuse, it is more appropriate that the family member or friend be made protective payee rather than a local office staff member or outside agency. In addition, a client's landlord, landlord's employee or vendor of goods or services to the client will not be assigned as a protective payee.

When it is determined that the protective payment plan is no longer necessary to ensure that the AFDC grant is being used to meet the needs of the family or when the former caretaker relative is no longer receiving and no longer requires treatment for substance abuse, the protective payment plan will be terminated.

- 16) Information and questions regarding these Adopted Amendments shall be directed to:

Name: Judy Umunna
Address: Bureau of Rules and Regulations
Illinois Department of Public Aid
100 South Grand Avenue East, Third Floor
Springfield, Illinois 62762
Telephone: (217) 524-3215

The full text of the Adopted Amendments begins on the next page:

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 117
RELATED PROGRAM PROVISIONS

Section	
117.1	Incorporation By Reference
117.10	Payee for Fee Financial Assistance
117.15	Reinstatement Upon Agreement to Cooperate
117.20	Replacement of Missing Warrants
117.30	Withholding of Rent (Repealed)
117.40	Recovery of Interim Assistance -- Aid to the Aged, Blind or Disabled and General Assistance
117.50	Funerals and Burials
117.51	Funeral Home Services
117.52	Burial Expenses
117.53	Payment to Vendor(s)
117.54	Claims for Reimbursement
117.55	Submittal of Claims
117.60	Substitute Parental Care/Supplemental Child Care - AFDC, AABD and GA Family Cases
117.70	Charge for Replacement of Photo ID Cards (Repealed)
117.80	Direct Deposit of Recipients' Warrants
117.90	State Income Tax Match

AUTHORITY: Implementing Articles III, IV and VI and authorized by Section 12-13 of the Illinois Public Aid Code (Ill.-Rev.-Stat.-1991-eh.-23-par.3-1 et-seq.-4-1-et-seq.-6-1-et-seq.-and-12-13) [305 ILCS 5/Arts. 3-1-et-seq., 5/4-1-et-seq., 5/6-1-et-seq. and 5/12-13].

SOURCE: Filed and effective December 30, 1977; amended at 2 Ill. Reg. 31, p. 68, effective August 3, 1978; amended at 3 Ill. Reg. 38, p. 258, effective September 20, 1979; amended at 3 Ill. Reg. 41, p. 167, effective October 1, 1979; codified at 7 Ill. Reg. 5195; amended at 7 Ill. Reg. 16111, effective November 22, 1983; amended at 9 Ill. Reg. 3726, effective March 13, 1985; amended at 9 Ill. Reg. 4526, effective March 20, 1985; amended at 9 Ill. Reg. 8733, effective May 29, 1985; amended at 9 Ill. Reg. 10779, effective July 5, 1985; amended at 9 Ill. Reg. 16914, effective October 16, 1985; amended at 11 Ill. Reg. 4759, effective March 13, 1987; amended at 12 Ill. Reg. 2985, effective January 13, 1988; amended at 12 Ill. Reg. 13608, effective August 15, 1988; amended at 12 Ill. Reg. 14296, effective August 30, 1988; amended at 13 Ill. Reg. 3936, effective March 10, 1989; amended at 14 Ill. Reg. 780, effective January 1, 1990; amended at 14 Ill. Reg. 9488, effective June 1, 1990; amended at 15 Ill. Reg. 13533, effective August 29, 1991; amended at 16 Ill. Reg. 16644, effective October 23, 1992; emergency amendment at 17 Ill.

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

Reg. 2368, effective February 8, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 8191, effective May 24, 1993; amended at 18 Ill. Reg. _____, effective February 28, 1994.

NOTE: CAPITALIZATION DENOTES STATUTORY LANGUAGE

Section 117.10 Payee for Fee Financial Assistance

- a) The assistance grant shall be paid to an individual designated as the payee.
- b) The individual receiving assistance shall be designated as the payee with the following exceptions:
 - 1) When a client has a judicially appointed conservator or guardian, payment shall be made to the conservator or guardian unless other arrangements are made with the Department by the conservator or guardian.
 - 2) In a situation where no specified relative is available to act as payee, another person may act as Temporary Grantee for a period not to exceed 90 days.
 - 3) A protective payment plan (PPP) is initiated by the Department when a client has demonstrated mismanagement of funds to the detriment of the welfare of the client or family. Examples include but are not limited to:

A) A client defaults on an agreement made with a utility company and the Department in the client's behalf. In this instance, when the protective payee receives the assistance payment, payment on current and back utility charges only shall be paid by the payee; the balance of the payment shall be forwarded to the client each month.

B) For AFDC only - When a child in the assistance unit is determined to be neglected by the Department of Children and Family Services under Section 3 of the Abused and Neglected Child Reporting Act (Ill.-Rev.-Stat.-1991-eh.-23-par.-2053) [325 ILCS 5/3] and 89 Ill. Adm. Code 300.APPENDIX B.

C) For AFDC only - The case involves a record establishing that a parent or relative has been found guilty of public assistance fraud under Article VIII A of the Illinois Public Aid Code (Ill.-Rev.-Stat.-1991-eh.-23-par.6-8A-1 et-seq.) [305 ILCS 5/Art. 8A].

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

Section 117.10(b)(3) (continued)

- D) Nonpayment of rent for two months shall be considered as evidence of grant management.
- E) Substance abuse by the caretaker relative is identified and another family member or friend is ensuring that the family's needs are being met.
- c) Notice shall be sent to the client before a protective payment plan is initiated.
- d) The protective payee shall not receive compensation and must agree to assume responsibility for the expenditure of the assistance payment in behalf of the client.
- e) The client's landlord or a vendor of goods or services to the client shall not be designated a protective payee.
- f) The Department may designate private welfare or social service agencies to serve as protective payees.
- g) When no other suitable payee is available, the Department may appoint a member of its staff to act as protective payee. However, the staff acting as protective payee may not be:

- 1) a person determining the client's eligibility or level of assistance;
- 2) a person handling fiscal processing relating to the recipient;
- 3) investigative staff; or
- 4) a local office administrator.

- h) The need for continuation of a protective payment plan and the performance of the protective payee shall be reviewed and evaluated by the Department as often as circumstances indicate, or, for AFDC cases at least every 12 months.

(Source: Amended at 18 Ill. Reg. _____, effective February 28, 1994)

DEPARTMENT OF CONSERVATION

NOTICE OF EMERGENCY AMENDMENTS

- 1) HEADING OF THE PART: The Taking of Wild Turkeys - Spring Season

- 2) CODE CITATION: 17 Ill. Adm. Code 710

- 3) SECTION NUMBERS: EMERGENCY ACTION:

710.10

Amendments

- 4) STATUTORY AUTHORITY: Implementing and authorized by Sections 1.3, 1.4, 1.20, 2.9, 2.10 and 2.11 of the Wildlife Code (Ill. Rev. Stat. 1991, ch. 61, pars. 1.3, 1.4, 1.20, 2.9, 2.10 and 2.11) [520 ILCS 5/1.3, 1.4, 1.20, 2.9, 2.10 and 2.11].

- 5) EFFECTIVE DATE OF AMENDMENTS: MAR 01 1994

- 6) IF THIS EMERGENCY AMENDMENT IS TO EXPIRE BEFORE THE END OF THE 150-DAY PERIOD, PLEASE SPECIFY THE DATE ON WHICH IT IS TO EXPIRE: This emergency amendment will remain in effect for the 150-day period.

- 7) DATE FILED IN AGENCY'S PRINCIPAL OFFICE: March 1, 1994

- 8) REASON FOR EMERGENCY: Language in this administrative rule inadvertently placed Bond County in both the Northern and Southern zones. It should have been listed under the Southern zone. This emergency has been proposed so that hunters will be able to determine proper season dates.

- 9) A COMPLETE DESCRIPTION OF THE SUBJECTS AND ISSUES INVOLVED: Currently Bond County is listed under the Northern zone in Section 710.10(c), it is being moved to the Southern zone in Section 710.10(c).

- 10) ARE THERE ANY PROPOSED AMENDMENTS TO THIS PART PENDING? No

- 11) STATEMENT OF STATEWIDE POLICY OBJECTIVES (if applicable):

- 12) INFORMATION AND QUESTIONS REGARDING THESE AMENDMENTS SHALL BE DIRECTED TO:

Jack Price
Department of Conservation
524 S. Second Street, Room 485
Springfield, IL 62701-1787

THE FULL TEXT OF THE EMERGENCY AMENDMENTS BEGINS ON THE NEXT PAGE:

DEPARTMENT OF CONSERVATION

NOTICE OF EMERGENCY AMENDMENTS

TITLE 17: CONSERVATION
CHAPTER 1: DEPARTMENT OF CONSERVATION
SUBCHAPTER b: FISH AND WILDLIFE

PART 710

THE TAKING OF WILD TURKEYS - SPRING SEASON

Section	
710.5	Hunting Zones
710.10	Hunting Seasons
EMERGENCY	
710.20	Statewide Turkey Permit Requirements
710.21	Turkey Permit Requirements - Special Hunts
	(Renumbered)
710.22	Turkey Permit Requirements - Landowner/Tenant Permits
710.25	Turkey Permit Requirements - Special Hunts
710.30	Turkey Hunting Regulations
710.40	Other Regulations (Repealed)
710.50	Regulations at Various Department Owned or Managed Sites
710.60	Releasing or Stocking of Turkeys

AUTHORITY: Implementing and authorized by Sections 1.3, 1.4, 1.20, 2.9, 2.10 and 2.11 of the Wildlife Code (Ill. Rev. Stat. 1991, ch. 61, pars. 1.3, 1.4, 1.20, 2.9, 2.10 and 2.11) [520 ILCS 5/1.3, 1.4, 1.20, 2.9, 2.10 and 2.11].

SOURCE: Adopted at 4 Ill. Reg. 15, p. 153, effective April 1, 1980; codified at 5 Ill. Reg. 10643; amended at 6 Ill. Reg. 3852, effective March 31, 1982; amended at 7 Ill. Reg. 4208, effective March 25, 1983; amended at 8 Ill. Reg. 5663, effective April 16, 1984, amended at 9 Ill. Reg. 6200, effective April 24, 1985; amended at 10 Ill. Reg. 6848, effective April 4, 1986; amended at 11 Ill. Reg. 2267, effective January 20, 1987; amended at 12 Ill. Reg. 5342, effective March 8, 1988; amended at 13 Ill. Reg. 5090, effective April 4, 1989; amended at 14 Ill. Reg. 663, effective January 2, 1990; amended at 15 Ill. Reg. 4161, effective March 4, 1991; amended at 16 Ill. Reg. 1843, effective January 17, 1992; amended at 17 Ill. Reg. 3184, effective March 2, 1993; amended at 18 Ill. Reg. 1156, effective January 18, 1994; emergency amendments at 18 Ill. Reg. _____, effective MAR 01 1994 for a maximum of 150 days.

Section 710.10 Hunting Seasons
EMERGENCY

a) Northern Zone Season Dates:

DEPARTMENT OF CONSERVATION

NOTICE OF EMERGENCY AMENDMENTS

1st Season:	Monday, April 11 - Friday, April 15, 1994.
2nd Season:	Saturday, April 16 - Thursday, April 21, 1994.
3rd Season:	Friday, April 22 - Friday, April 29, 1994.
4th Season:	Saturday, April 30 - Wednesday, May 11, 1994
b) Southern Zone Season Dates:	
1st Season:	Monday, April 4, - Friday, April 8, 1994
2nd Season:	Saturday, April 9 - Thursday, April 14, 1994
3rd Season:	Friday, April 15 - Friday, April 22, 1994
4th Season:	Saturday, April 23 - Wednesday, May 4, 1994

c) Open Counties:

NORTHERN ZONE

Adams
Bond _____ (west of State Highway 127-only)
Brown
Bureau
Calhoun
Carroll
Cass
Clark
Cumberland
Fulton
Greene
Hancock
Henderson
Jersey
Jo Daviess
Knox
Lee
Macoupin

ILLINOIS REGISTER

DEPARTMENT OF CONSERVATION

NOTICE OF EMERGENCY AMENDMENTS

Marshall-Putnam (east of Illinois River only; north of State Highway 17 and south of the McNabb Blacktop (County Road 500 N.) only)

Mason

Morgan

McDonough

Mercer

Ogle

Pike

Rock Island

Schuyler

Scott

Stephenson

Tazewell

Whiteside

Winnebago

SOUTHERN ZONE

Alexander

Bond (west of State Highway 127 only)

Clay

Effingham

Fayette

Gallatin-Hardin

Jackson

Johnson

Marion

Monroe

Pope

Randolph

Saline

St. Clair

Union

Washington

Williamson

(Source: Emergency amendments at 18 Ill. Reg. _____, effective MAR 01 1994, for a maximum of 150 days)

ILLINOIS REGISTER

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF EMERGENCY REPEALER

1) The Heading of the Part:

The Illinois Formulary for the Drug Product Selection Program

2) Code Citation:

77 Ill. Adm. Code 790

3) Section Numbers:

790.20

790.40

790.60

790.80

790.100

790.120

790.140

790.160

790.180

790.200

790.220

790.240

790.260

790.280

790.300

790.320

Emergency Action:

Repealer

Repealer

Repealer

Repealer

Repealer

Repealer

Repealer

Repealer

Repealer

Repealer

Repealer

Repealer

Repealer

Repealer

Repealer

Repealer

4) Statutory Authority:

Implementing and authorized by Section 3.14 of the Illinois Food, Drug and Cosmetic Act (Ill. Rev. Stat. 1991, ch. 56 1/2, par. 503.14) [410 ILCS 620/3.14] and Section 25 of the Pharmacy Practice Act (Ill. Rev. Stat. 1991, ch. 111, par. 4145) [225 ILCS 85/25].

5) Effective Date of Emergency Repealer:

February 22, 1994

6) If this Emergency Repealer is to Expire Before the End of the 150-Day Period, Please Specify the Date on Which it is to Expire:

Not Applicable

7) Date Filed in Agency's Principal Office:

DEPARTMENT OF PUBLIC HEALTH
NOTICE OF EMERGENCY REPEALER

February 22, 1994

8) Reason for Emergency:

The Department is proceeding with this rulemaking as an emergency because of the potential adverse economic impact its delay would have upon the prescription consuming public and the third-party prescription reimbursement sector of the health care economy. This rulemaking will make savings available to individuals paying for prescription medications on an out-of-pocket basis and those insurance, employer and pension programs that pay for their beneficiaries' prescription medications. The biggest potential recipient of such savings is the Department of Public Aid, which over time will be able to establish generic reimbursement limits for several additional pharmaceuticals now currently limited to premium brand name prices.

9) A Complete Description of the Subjects and Issues Involved:

These repealed rules will be replaced by new emergency rules which became effective on the same date as the repeal of the existing rules and appear in this issue of the Illinois Register.

10) Are There Any Proposed Amendments Pending on this Part?

Yes _____ No ✓

11) Statement of Statewide Policy Objectives:

These rules will not require any new expenditures by units of local government.

12) Information and Questions Regarding this Emergency Repealer shall be directed to:

Gail M. DeVito
535 West Jefferson, Fifth Floor
Springfield, Illinois 62761
217/782-6187

The full text of the Emergency Repealer begins on the next page:

DEPARTMENT OF PUBLIC HEALTH
NOTICE OF EMERGENCY REPEALER

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER m: FOOD, DRUGS AND COSMETICS

PART 790
THE ILLINOIS FORMULARY FOR THE DRUG PRODUCT SELECTION PROGRAM
SUBPART A: GENERAL PROVISIONS

SECTION	Introduction
EMERGENCY 790.20	
EMERGENCY 790.40	Consideration of Drug Products for Inclusion in the Illinois Formulary
EMERGENCY 790.60	Additional Criteria
EMERGENCY 790.80	Quality Listing
EMERGENCY 790.100	Generic Drug Entity Headings
EMERGENCY 790.120	Comments and Specific Administration
EMERGENCY 790.140	Requests for Additional Copies
EMERGENCY 790.160	Prescription Use of Drug Products
EMERGENCY 790.180	FDA Drug Product Approval and Recommendation
EMERGENCY 790.200	Availability of Drug Products; Pharmaceutical Equivalence
EMERGENCY 790.220	Single Source Drug Products Exclusion
EMERGENCY 790.240	Criteria for Exclusion of Drug Products
EMERGENCY 790.260	Inclusion of Controlled Substances
EMERGENCY 790.280	Equivalence of Products Requirements
EMERGENCY 790.300	Selection of Equivalent Drug Products
EMERGENCY 790.320	Transfer of Prescription Records
EMERGENCY	

SUBPART B: APPROVED DRUG PRODUCTS FOR

DEPARTMENT OF PUBLIC HEALTH

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DRUG PRODUCT SELECTION

SECTION	
790.420	ACETAMINOPHEN; BUTALBITAL (Repealed)
790.460	ACETAMINOPHEN; BUTALBITAL; CAFFEINE (Repealed)
790.480	ACETAMINOPHEN; CAFFEINE; DIHYDROCODEINE BITARTRATE (Repealed)
790.500	ACETAMINOPHEN; CODEINE PHOSPHATE (Repealed)
790.540	ACETAMINOPHEN; HYDROCODONE BITARTRATE (Repealed)
790.548	ACETAMINOPHEN; OXYCODONE HYDROCHLORIDE (Repealed)
790.580	ACETAMINOPHEN; PROPOXYPHENE HYDROCHLORIDE (Repealed)
790.600	ACETAMINOPHEN; PROPOXYPHENE NAPSYLATE (Repealed)
790.620	ACETAZOLAMIDE (Repealed)
790.630	ACETAZOLAMIDE SODIUM (Repealed)
790.660	ACETIC ACID; GLACIAL (Repealed)
790.700	ACETIC ACID; GLACIAL; HYDROCORTISONE (Repealed)
790.706	ACETOHEXAMIDE (Repealed)
790.721	ACETYLCYSTEINE (Repealed)
790.740	ALBUTEROL SULFATE (Repealed)
790.756	ALCOHOL; DEXTROSE (Repealed)
790.760	ALCOHOL; MORPHINE (Repealed)
790.780	ALLOPURINOL (Repealed)
790.788	AMANTADINE HYDROCHLORIDE (Repealed)
790.799	AMILORIDE HYDROCHLORIDE (Repealed)
790.798	AMILORIDE HYDROCHLORIDE; HYDROCHLOROTHIAZIDE (Repealed)
790.815	AMINOACETIC ACID (Repealed)
790.820	AMINOCAPROIC ACID (Repealed)
790.830	AMINOPHOSPHATE SODIUM (Repealed)
790.860	AMINOPHYLLINE (Repealed)
790.900	AMITRIPTYLINE HYDROCHLORIDE (Repealed)
790.905	AMITRIPTYLINE HYDROCHLORIDE; CHLORDIAZEPOXIDE (Repealed)
790.910	AMITRIPTYLINE HYDROCHLORIDE; PERPHENAZINE (Repealed)
790.920	AMOXAPINE (Repealed)
790.940	AMOXICILLIN TRIHYDRATE (Repealed)
790.974	AMPHOTERICIN B (Repealed)
790.980	AMPICILLIN SODIUM (Repealed)
790.1020	AMPICILLIN; PROBENECID (Repealed)
790.1060	AMPICILLIN/AMPCILLIN TRIHYDRATE (Repealed)
790.1100	ANISOTROPINE METHYLBROMIDE (Repealed)
790.1107	ANTAZOLINE PHOSPHATE; NAPHAZOLINE HYDROCHLORIDE (Repealed)
790.1112	ANTIPYRINE; BENZOCAINE (Repealed)
790.1112	ASCORBIC ACID; BIOTIN; CYANOCOBALAMIN; DEXPANATHENOL; ERGOCALCIFEROL; FOLIC ACID; NIACINAMIDE; PYRIDOXINE HYDROCHLORIDE; RIBOFLAVIN PHOSPHATE SODIUM; THIAMINE

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790.1125	HYDROCHLORIDE; VITAMIN A; VITAMIN E (Repealed) ASCORBIC ACID; CYANOCOBALAMIN; FLUORIDE; IRON; NICOTINIC ACID; PYRIDOXINE HYDROCHLORIDE; RIBOFLAVIN; THIAMINE HYDROCHLORIDE; VITAMIN A; VITAMIN D; VITAMIN E (Repealed)
790.1127	ASCORBIC ACID; CYANOCOBALAMIN; FLUORIDE; NICOTINIC ACID; PYRIDOXINE HYDROCHLORIDE; RIBOFLAVIN; THIAMINE HYDROCHLORIDE; VITAMIN A; VITAMIN D; VITAMIN E (Repealed)
790.1129	ASCORBIC ACID; FLUORIDE; IRON; VITAMIN A; VITAMIN D (Repealed)
790.1131	ASCORBIC ACID; FLUORIDE; VITAMIN A; VITAMIN D (Repealed)
790.1140	ASPIRIN; BUTALBITAL; CAFFEINE (Repealed)
790.1180	ASPIRIN; BUTALBITAL; CAFFEINE; PHENACETIN (Repealed)
790.1200	ASPIRIN; CAFFEINE; ORPHENADRINE CITRATE (Repealed)
790.1220	ASPIRIN; CAFFEINE; PHENACETIN; PROPOXYPHENE HYDROCHLORIDE (Repealed)
790.1260	ASPIRIN; CAFFEINE; PHENACETIN; PROPOXYPHENE HYDROCHLORIDE (Repealed)
790.1300	ASPIRIN; CAFFEINE; PROPOXYPHENE HYDROCHLORIDE (Repealed)
790.1345	ASPIRIN; CARISOPRODOL (Repealed)
790.1350	ASPIRIN; CODEINE PHOSPHATE (Repealed)
790.1360	ASPIRIN; MEPROBAMATE (Repealed)
790.1380	ASPIRIN; METHOCARBAMOL (Repealed)
790.1386	ASPIRIN; OXYCODONE HYDROCHLORIDE; OXYCODONE TEREPHTHALATE (Repealed)
790.1388	ATENOLOL (Repealed)
790.1390	ATENOLOL; CHLORTHALIDONE (Repealed)
790.1418	ATROPINE SULFATE (Repealed)
790.1420	ATROPINE SULFATE; DIPHENOXYLATE HYDROCHLORIDE (Repealed)
790.1423	ATROPINE SULFATE; HYOSCYAMINE; PHENOBARBITAL; SCOPOLAMINE HYDROBROMIDE (Repealed)
790.1425	ATROPINE SULFATE; MEPERIDINE HYDROCHLORIDE (Repealed)
790.1440	AZATHIOPRINE SODIUM (Repealed)
790.1460	BACTRACIN (Repealed)
790.1490	BACTRACIN ZINC; HYDROCORTISONE; NEOMYCIN SULFATE; POLYMYXIN B SULFATE (Repealed)
790.1500	BACTRACIN ZINC; NEOMYCIN SULFATE; POLYMYXIN B SULFATE (Repealed)
790.1540	BACTRACIN ZINC; POLYMYXIN B SULFATE (Repealed)
790.1560	BACTOFEN (Repealed)
790.1570	BENZTROPINE MESYLATE (Repealed)
790.1573	BIPHENYL HYDROCHLORIDE (Repealed)
790.1577	BETAMETHASONE DIPROPIONATE (Repealed)
790.1580	BETAMETHASONE SODIUM PHOSPHATE (Repealed)
790.1670	BETAMETHASONE VALERATE (Repealed)

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790.1660	BETHANECHOL CHLORIDE (Repealed)
790.1685	BRETYLIUM TOSYLATE (Repealed)
790.1686	BRETYLIUM TOSYLATE; DEXTROSE (Repealed)
790.1697	BROMODIPHENHYDRAMINE HYDROCHLORIDE; CODEINE PHOSPHATE (Repealed)
790.1700	BROMPHENIRAMINE MALEATE (Repealed)
790.1706	BROMPHENIRAMINE MALEATE; CODEINE PHOSPHATE;
	PHENYLPROPANOLAMINE HYDROCHLORIDE (Repealed)
790.1708	BROMPHENIRAMINE MALEATE; DEXTROMETHORPHAN HYDROBROMIDE;
	PSEUDOEPHEDRINE HYDROCHLORIDE (Repealed)
790.1710	BROMPHENIRAMINE MALEATE; PHENYLPROPANOLAMINE HYDROCHLORIDE (Repealed)
790.1719	BUPIVACAINE HYDROCHLORIDE (Repealed)
790.1721	BUPIVACAINE HYDROCHLORIDE; EPINEPHRINE BITARTRATE (Repealed)
790.1740	BUTABARBITAL SODIUM (Repealed)
790.1780	CAFFEINE; CARISOPRODOL; PHENACETIN (Repealed)
790.1820	CAFFEINE; ERGOTAMINE TARTRATE (Repealed)
790.1830	CALCITONIN; SALMON (Repealed)
790.1835	CALCIUM CHLORIDE; DEXTROSE; GLUTATHIONE DISULFIDE; MAGNESIUM CHLORIDE; POTASSIUM CHLORIDE; SODIUM BICARBONATE; SODIUM CHLORIDE; SODIUM PHOSPHATE (Repealed)
790.1842	CALCIUM CHLORIDE; DEXTROSE; MAGNESIUM CHLORIDE; SODIUM CHLORIDE; SODIUM LACTATE (Repealed)
790.1846	CALCIUM CHLORIDE; DEXTROSE; POTASSIUM CHLORIDE; SODIUM CHLORIDE (Repealed)
790.1848	CALCIUM CHLORIDE; DEXTROSE; POTASSIUM CHLORIDE; SODIUM CHLORIDE; SODIUM LACTATE (Repealed)
790.1856	CALCIUM CHLORIDE; POTASSIUM CHLORIDE; SODIUM CHLORIDE (Repealed)
790.1858	CALCIUM CHLORIDE; POTASSIUM CHLORIDE; SODIUM CHLORIDE; SODIUM LACTATE (Repealed)
790.1860	CALCIUM GLUCEPTATE (Repealed)
790.1870	CALCIUM GLUCONATE (Repealed)
790.1900	CANDICIDIN (Repealed)
790.1930	CARBAMAZEPINE (Repealed)
790.1940	CARBENICILLIN DISODIUM (Repealed)
790.1950	CARBINOXAMINE MALEATE; DEXTROMETHORPHAN HYDROBROMIDE; PSEUDOEPHEDRINE HYDROCHLORIDE (Repealed)
790.1960	CARBINOXAMINE MALEATE; PSEUDOEPHEDRINE HYDROCHLORIDE (Repealed)
790.1980	CARISOPRODOL (Repealed)
790.2020	CEFADROXIL MONOHYDRATE (Repealed)
790.2060	CEFAZOLIN SODIUM (Repealed)

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790.2084	CEFTAZIDIME (Repealed)
790.2092	CEFUROXIME SODIUM (Repealed)
790.2097	CEPHALEXIN (Repealed)
790.2100	CEPHALOTHIN SODIUM (Repealed)
790.2130	CEPHAPIRIN SODIUM (Repealed)
790.2140	CEPHRADINE/CEPHRADINE DIHYDRATE (Repealed)
790.2155	CHLORAL HYDRATE (Repealed)
790.2180	CHLORAMPHENICOL (Repealed)
790.2220	CHLORAMPHENICOL SODIUM SUCCINATE (Repealed)
790.2260	CHLORDIAZEPOXIDE HYDROCHLORIDE (Repealed)
790.2300	CHLORMEZANONE (Repealed)
790.2340	CHLOROQUINE PHOSPHATE (Repealed)
790.2380	CHLOROTHIAZIDE (Repealed)
790.2390	CHLOROTHIAZIDE; METHYLDOPA (Repealed)
790.2420	CHLOROTRIANISENE (Repealed)
790.2460	CHLORPHENIRAMINE MALEATE (Repealed)
790.2462	CHLORPHENIRAMINE MALEATE; CODEINE PHOSPHATE; PSEUDOEPHEDRINE HYDROCHLORIDE (Repealed)
790.2465	CHLORPHENIRAMINE MALEATE; PHENYLEPHRINE HYDROCHLORIDE; PHENYLPROPANOLAMINE HYDROCHLORIDE; PHENYLTOLOXAMINE CITRATE (Repealed)
790.2470	CHLORPHENIRAMINE MALEATE; PHENYLPROPANOLAMINE HYDROCHLORIDE (Repealed)
790.2485	CHLORPHENIRAMINE TANNATE; PHENYLEPHRINE TANNATE; PYRILAMINE TANNATE (Repealed)
790.2500	CHLORPROMAZINE HYDROCHLORIDE (Repealed)
790.2510	CHLORPROPAMIDE (Repealed)
790.2540	CHLORTHALIDONE (Repealed)
790.2555	CHLORTHALIDONE; CLONIDINE HYDROCHLORIDE (Repealed)
790.2580	CHLORZOXAZONE (Repealed)
790.2583	CHROMIC CHLORIDE (Repealed)
790.2595	CITRIC ACID; MAGNESIUM OXIDE; SODIUM CARBONATE (Repealed)
790.2603	CLINDAMYCIN HYDROCHLORIDE (Repealed)
790.2605	CLINDAMYCIN PHOSPHATE (Repealed)
790.2613	CLOFIBRATE (Repealed)
790.2614	CLOMIPHENE CITRATE (Repealed)
790.2617	CLONIDINE HYDROCHLORIDE (Repealed)
790.2618	CLORAZEPATE DIPOTASSIUM (Repealed)
790.2620	CLOTIMAZOLE (Repealed)
790.2645	CLOXACILLIN SODIUM MONOHYDRATE (Repealed)
790.2655	CODEINE PHOSPHATE; GUAIFENESIN (Repealed)
790.2660	CLOXACILLIN SODIUM MONOHYDRATE (Repealed)
790.2661	CODEINE PHOSPHATE; GUAIFENESIN; PSEUDOEPHEDRINE HYDROCHLORIDE (Repealed)

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790.2662 CODEINE PHOSPHATE; IODINATED GLYCEROL (Repealed)
 790.2663 CODEINE PHOSPHATE; PHENYLEPHRINE HYDROCHLORIDE;
 PROMETHAZINE HYDROCHLORIDE (Repealed)
 790.2668 CODEINE PHOSPHATE; PROMETHAZINE HYDROCHLORIDE (Repealed)
 790.2672 CODEINE PHOSPHATE; PSEUDOEPHEDRINE HYDROCHLORIDE;
 TRIPROLIDINE HYDROCHLORIDE (Repealed)
 790.2700 CORTICOTROPIN (Repealed)
 790.2740 CROTAMITON (Repealed)
 790.2780 CYANOCOBALAMIN (Repealed)
 790.2800 CYCLACILLIN (Repealed)
 790.2805 CYCLOBENZAPRINE HYDROCHLORIDE (Repealed)
 790.2820 CYCLOPENTOLATE HYDROCHLORIDE (Repealed)
 790.2860 CYCLOPHOSPHAMIDE (Repealed)
 790.2900 CYPROHEPTADINE HYDROCHLORIDE (Repealed)
 790.2902 CYTARABINE (Repealed)
 790.2904 DACARBAZINE (Repealed)
 790.2908 DANAZOL (Repealed)
 790.2915 DAUNORUBICIN HYDROCHLORIDE (Repealed)
 790.2928 DESIPRAMINE HYDROCHLORIDE (Repealed)
 790.2932 DESONIDE (Repealed)
 790.2940 DEXAMETHASONE (Repealed)
 790.2980 DEXAMETHASONE; NEOMYCIN SULFATE; POLYMYXIN B SULFATE
 (Repealed)
 790.3020 DEXAMETHASONE SODIUM PHOSPHATE (Repealed)
 790.3021 DEXAMETHASONE SODIUM PHOSPHATE; NEOMYCIN SULFATE
 (Repealed)
 790.3023 DEXCHLORPHENIRAMINE MALEATE (Repealed)
 790.3025 DEXTROAMPHETAMINE SULFATE (Repealed)
 790.3027 DEXTROMETHORPHAN HYDROBROMIDE; IODINATED GLYCEROL
 (Repealed)
 790.3028 DEXTROMETHORPHAN HYDROBROMIDE; PROMETHAZINE
 HYDROCHLORIDE (Repealed)
 790.3029 DEXTROSE (Repealed)
 790.3030 DEXTROSE; DOPAMINE HYDROCHLORIDE (Repealed)
 790.3032 DEXTROSE; HEPARIN SODIUM (Repealed)
 790.3033 DEXTROSE; LIDOCAINE HYDROCHLORIDE (Repealed)
 790.3038 DEXTROSE; MAGNESIUM CHLORIDE; POTASSIUM CHLORIDE; SODIUM
 ACETATE; SODIUM CHLORIDE; SODIUM GLUCONATE (Repealed)
 790.3042 DEXTROSE; POTASSIUM CHLORIDE (Repealed)
 790.3048 DEXTROSE; POTASSIUM CHLORIDE (Repealed)
 790.3049 DEXTROSE; SODIUM CHLORIDE; SODIUM CHLORIDE (Repealed)
 790.3051 DEXTROSE; THEOPHYLLINE (Repealed)
 790.3054 DIAZEPAM (Repealed)
 790.3056 DIAZOXIDE (Repealed)

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790.3060 DICLOXACILLIN SODIUM (Repealed)
 790.3085 DICYCLOMINE HYDROCHLORIDE (Repealed)
 790.3100 DIENESTROL (Repealed)
 790.3140 DIETHYLPROPION HYDROCHLORIDE (Repealed)
 790.3180 DIETHYLSTILBESTROL (Repealed)
 790.3220 DIGOXIN (Repealed)
 790.3260 DIMENHYDRINATE (Repealed)
 790.3300 DIPHENHYDRAMINE HYDROCHLORIDE (Repealed)
 790.3308 DIPYRIDAMOLE (Repealed)
 790.3315 DISOPYRAMIDE PHOSPHATE (Repealed)
 790.3335 DOPAMINE HYDROCHLORIDE (Repealed)
 790.3340 DOXEPIN HYDROCHLORIDE (Repealed)
 790.3350 DOXORUBICIN HYDROCHLORIDE (Repealed)
 790.3380 DOXYCYCLINE (Repealed)
 790.3420 DOXYCYCLINE HYCLATE (Repealed)
 790.3425 DOXYLAMINE SUCCINATE (Repealed)
 790.3437 DROPERIDOL (Repealed)
 790.3440 DROPERIDOL; FENTANYL CITRATE (Repealed)
 790.3460 ECHTHIOPHATE IODIDE (Repealed)
 790.3472 EDETATE DISODIUM (Repealed)
 790.3475 EDROPHONIUM CHLORIDE (Repealed)
 790.3480 EPHEDRINE; HYDROXYZINE HYDROCHLORIDE; THEOPHYLLINE
 (Repealed)
 790.3488 EPINEPHRINE HYDROCHLORIDE (Repealed)
 790.3492 EPINEPHRINE; LIDOCAINE HYDROCHLORIDE (Repealed)
 790.3495 EPOETIN ALPHA (Repealed)
 790.3500 ERGOCALCIFEROL (Repealed)
 790.3540 ERGOLOID MESYLATES (Repealed)
 790.3580 ERGOTAMINE TARTRATE (Repealed)
 790.3620 ERYTHROMYCIN (Repealed)
 790.3660 ERYTHROMYCIN ESTOLATE (Repealed)
 790.3700 ERYTHROMYCIN ETHYLSUCCINATE (Repealed)
 790.3720 ERYTHROMYCIN ETHYLSUCCINATE; SULFISOXAZOLE ACETYL
 (Repealed)
 790.3730 ERYTHROMYCIN LACTOBIONATE (Repealed)
 790.3740 ERYTHROMYCIN STEARATE (Repealed)
 790.3742 ERYTHROMYCIN STEARATE (Repealed)
 790.3780 ESTRADIOL CYPIONATE (Repealed)
 790.3800 ESTRADIOL CYPIONATE; TESTOSTERONE CYPIONATE (Repealed)
 790.3820 ESTRADIOL VALERATE (Repealed)
 790.3860 ESTRADIOL VALERATE; TESTOSTERONE ENANTHATE (Repealed)
 790.3875 ESTROPIRATE (PIPERAZINE ESTRONE SULFATE) (Repealed)
 790.3900 ETHCHLORVYNOL (Repealed)
 790.3904 ETHINYL ESTRADIOL; LEVONORGESTREL (Repealed)

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790.3907	ETHINYL ESTRADIOL; NORETHINDRONE (Repealed)
790.3910	FENOPROFEN CALCIUM (Repealed)
790.3914	FENTANYL CITRATE (Repealed)
790.3920	FLOXURIDINE (Repealed)
790.3940	FLUOCINOLONE ACETONIDE (Repealed)
790.3945	FLUOCINONIDE (Repealed)
790.3960	FLUOROMETHOLONE (Repealed)
790.3980	FLUOROURACIL (Repealed)
790.3996	FLUPHENAZINE DECANOATE (Repealed)
790.4012	FLUPHENAZINE HYDROCHLORIDE (Repealed)
790.4020	FLURANDRENOLIDE (Repealed)
790.4040	FLURAZEPAM HYDROCHLORIDE (Repealed)
790.4060	FOLIC ACID (Repealed)
790.4100	FUROSEMIDE (Repealed)
790.4140	GENTAMICIN SULFATE (Repealed)
790.4150	GENTAMICIN SULFATE; SODIUM CHLORIDE (Repealed)
790.4173	GLUCAGON HYDROCHLORIDE (Repealed)
790.4180	GLUTETHIMIDE (Repealed)
790.4200	GLYCINE (Repealed)
790.4220	GLYCOPYRROLATE (Repealed)
790.4260	GONADOTROPIN CHORIONIC (Repealed)
790.4300	GRAMICIDIN; NEOMYCIN SULFATE; POLYMYXIN B SULFATE (Repealed)
790.4340	GRISOFULVIN MICROCRYSTALLINE (Repealed)
790.4380	GRISOFULVIN ULTRAMICROCRYSTALLINE (Repealed)
790.4384	GUAIFENESIN; HYDROCODONE BITARTRATE; PSEUDOEPHEDRINE HYDROCHLORIDE (Repealed)
790.4385	GUAIFENESIN; THEOPHYLLINE (Repealed)
790.4386	GUANETHIDINE MONOSULFATE (Repealed)
790.4396	HALOPERIDOL (Repealed)
790.4398	HALOPERIDOL LACTATE (Repealed)
790.4420	HEPARIN SODIUM (Repealed)
790.4430	HEPARIN SODIUM; SODIUM CHLORIDE (Repealed)
790.4460	HEXACHLOROPHENE (Repealed)
790.4495	HOMATROPINE HYDROBROMIDE (Repealed)
790.4500	HOMATROPINE METHYLBROMIDE (Repealed)
790.4540	HOMATROPINE METHYLBROMIDE; HYDROCODONE BITARTRATE (Repealed)
790.4580	HYDRALAZINE HYDROCHLORIDE (Repealed)
790.4620	HYDRALAZINE HYDROCHLORIDE; HYDROCHLOROTHIAZIDE (Repealed)
790.4660	HYDROCHLOROTHIAZIDE (Repealed)
790.4665	HYDROCHLOROTHIAZIDE; LABETALOL HYDROCHLORIDE (Repealed)
790.4667	HYDROCHLOROTHIAZIDE; LISINAPRIL (Repealed)
790.4670	HYDROCHLOROTHIAZIDE; METHYLDOPA (Repealed)
790.4680	HYDROCHLOROTHIAZIDE; PROPRANOLOL HYDROCHLORIDE (Repealed)

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790.4700	HYDROCHLOROTHIAZIDE; SPIRONOLACTONE (Repealed)
790.4720	HYDROCHLOROTHIAZIDE; TRIAMTERENE (Repealed)
790.4725	HYDROCODONE BITARTRATE; PHENYLPROPANOLAMINE HYDROCHLORIDE (Repealed)
790.4728	HYDROCODONE BITARTRATE; PSEUDOEPHEDRINE HYDROCHLORIDE (Repealed)
790.4740	HYDROCORTISONE (Repealed)
790.4780	HYDROCORTISONE; NEOMYCIN SULFATE; POLYMYXIN B SULFATE (Repealed)
790.4820	HYDROCORTISONE; POLYMYXIN B SULFATE (Repealed)
790.4840	HYDROCORTISONE SODIUM PHOSPHATE (Repealed)
790.4860	HYDROCORTISONE; UREA (Repealed)
790.4900	HYDROCORTISONE ACETATE (Repealed)
790.4940	HYDROCORTISONE ACETATE; NEOMYCIN SULFATE (Repealed)
790.4960	HYDROCORTISONE ACETATE; PRAMOXINE HYDROCHLORIDE (Repealed)
790.4963	HYDROCORTISONE ACETATE; UREA (Repealed)
790.4965	HYDROCORTISONE BUTYRATE (Repealed)
790.4980	HYDROCORTISONE SODIUM SUCCINATE (Repealed)
790.5020	HYDROFLUMETHIAZIDE (Repealed)
790.5030	HYDROMORPHONE INJECTION (Repealed)
790.5060	HYDROXOCOBALAMIN (Repealed)
790.5100	HYDROXYPROGESTERONE CAPROATE (Repealed)
790.5140	HYDROXYZINE HYDROCHLORIDE (Repealed)
790.5180	HYDROXYZINE PAMOATE (Repealed)
790.5220	IBUPROFEN (Repealed)
790.5260	IDOXURIDINE (Repealed)
790.5300	IMPAMINE HYDROCHLORIDE (Repealed)
790.5312	INDOMETHACIN (Repealed)
790.5320	IODINATED GLYCEROL (Repealed)
790.5340	IRON DEXTRAN COMPLEX (Repealed)
790.5380	ISOETHARINE HYDROCHLORIDE (Repealed)
790.5420	ISONIAZID (Repealed)
790.5460	ISOPROTENOL HYDROCHLORIDE (Repealed)
790.5483	ISOSORBIDE DINITRATE (Repealed)
790.5500	KANAMYCIN SULFATE (Repealed)
790.5520	KETAMINE HYDROCHLORIDE (Repealed)
790.5530	LABETALOL HYDROCHLORIDE (Repealed)
790.5540	LACTULOSE (Repealed)
790.5544	LEUCOVORIN CALCIUM (Repealed)
790.5555	LEVOCARNITINE (Repealed)
790.5560	LEVONORDEFIN; MEPIVCAINE HYDROCHLORIDE (Repealed)
790.5580	LIDOCAINE (Repealed)
790.5620	LIDOCAINE HYDROCHLORIDE (Repealed)
790.5640	LINCOMYCIN (Repealed)

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790.5660	LINDANE (Repealed)
790.5700	LIOTHYRONINE SODIUM (Repealed)
790.5720	LISINAPRIL (Repealed)
790.5740	LITHIUM CARBONATE (Repealed)
790.5780	LITHIUM CITRATE (Repealed)
790.5788	LOPERAMIDE (Repealed)
790.5792	LORAZEPAM (Repealed)
790.5795	LOXAPINE SUCCINATE (Repealed)
790.5800	MAGNESIUM CHLORIDE; POTASSIUM CHLORIDE; SODIUM ACETATE; SODIUM CHLORIDE; SODIUM GLUCONATE (Repealed)
790.5802	MANNITOL (Repealed)
790.5807	MAPROTILINE HYDROCHLORIDE (Repealed)
790.5820	MECLIZINE HYDROCHLORIDE (Repealed)
790.5830	MECLOFENAMATE SODIUM (Repealed)
790.5835	MEDROXYPROGESTERONE ACETATE (Repealed)
790.5837	MEFENAMIC ACID (Repealed)
790.5840	MEGESTROL ACETATE (Repealed)
790.5860	MENADIOL SODIUM PHOSPHATE (Repealed)
790.5872	MEPERIDINE HYDROCHLORIDE (Repealed)
790.5893	MEPIVCAINE HYDROCHLORIDE (Repealed)
790.5900	MEPROBAMATE (Repealed)
790.5924	MESTRANOL; NORETHINDRONE (Repealed)
790.5940	METAPROTERENOL SULFATE (Repealed)
790.5980	METARAMINOL BITARTRATE (Repealed)
790.5992	METHADONE HYDROCHLORIDE (Repealed)
790.5996	METHAMPHETAMINE HYDROCHLORIDE (Repealed)
790.6020	METHDILAZINE HYDROCHLORIDE (Repealed)
790.6060	METHENAMINE HIPPURATE (Repealed)
790.6100	METHICILLIN SODIUM (Repealed)
790.6140	METHOCARBAMOL (Repealed)
790.6180	METHOTREXATE SODIUM (Repealed)
790.6220	METHSCOPOLAMINE BROMIDE (Repealed)
790.6260	METHYLCLOTHIAZIDE (Repealed)
790.6275	METHYLDOPA (Repealed)
790.6277	METHYLDOPATE HYDROCHLORIDE (Repealed)
790.6280	METHYLPHENIDATE HYDROCHLORIDE (Repealed)
790.6284	METHYLPREDNISOLONE (Repealed)
790.6300	METHYLPREDNISOLONE SODIUM SUCCINATE (Repealed)
790.6340	METHYLTOSTERONE (Repealed)
790.6370	METHOCLOPRAMIDE HYDROCHLORIDE (Repealed)
790.6375	METOCURINE IODIDE (Repealed)
790.6380	METOLAZONE (Repealed)
790.6420	METRONIDAZOLE (Repealed)
790.6440	MINOCYCLINE (Repealed)

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790.6435	MINOXIDIL (Repealed)
790.6445	MORPHINE SULFATE (Repealed)
790.6450	NAFCILLIN SODIUM (Repealed)
790.6452	NALBUPHINE HYDROCHLORIDE (Repealed)
790.6454	NALIDIXIC ACID (Repealed)
790.6456	NALOXONE HYDROCHLORIDE (Repealed)
790.6460	NANDROLONE DECANOATE (Repealed)
790.6480	NANDROLONE PHENPROPIONATE (Repealed)
790.6500	NAPHAZOLINE HYDROCHLORIDE (Repealed)
790.6505	NAPHAZOLINE HYDROCHLORIDE; PHENIRAMINE MALEATE (Repealed)
790.6540	NEOMYCIN SULFATE (Repealed)
790.6544	NEOMYCIN SULFATE; POLYMYXIN B SULFATE (Repealed)
790.6570	NEOMYCIN SULFATE; TRIAMCINOLONE ACETONIDE (Repealed)
790.6580	NIACIN (Repealed)
790.6610	NIFEDIPINE (Repealed)
790.6620	NITROFURANTOIN (Repealed)
790.6621	NITROFURANTOIN MACROCRYSTALS (Repealed)
790.6660	NITROFURAZONE (Repealed)
790.6670	NITROGLYCERIN INJECTION (Repealed)
790.6700	NORETHINDRONE ACETATE (Repealed)
790.6740	NORTRIPTYLINE HYDROCHLORIDE (Repealed)
790.6780	NYSTATIN (Repealed)
790.6800	NYSTATIN; TRIAMCINOLONE ACETONIDE (Repealed)
790.6820	ORPHENADRINE CITRATE (Repealed)
790.6860	OXACILLIN SODIUM (Repealed)
790.6875	OXAZEPAM (Repealed)
790.6885	OXTRIPHYLLINE (Repealed)
790.6895	OXYBUTYRIN (Repealed)
790.6900	OXYPHENBUTAZONE (Repealed)
790.6940	OXYTETRACYCLINE HYDROCHLORIDE (Repealed)
790.6946	OXYTOCIN (Repealed)
790.6960	PANCURONIUM BROMIDE (Repealed)
790.6980	PENICILLIN G POTASSIUM (Repealed)
790.7020	PENICILLIN G PROCAINE (Repealed)
790.7060	PENICILLIN G SODIUM (Repealed)
790.7100	PENICILLIN V POTASSIUM (Repealed)
790.7120	PENTOBARBITAL SODIUM (Repealed)
790.7130	PERPHENAZINE (Repealed)
790.7140	PHENIDMETRAZINE TARTRATE (Repealed)
790.7160	PHENOBARBITAL (Repealed)
790.7180	PHENTERMINE HYDROCHLORIDE (Repealed)
790.7181	PHENTERMINE RESIN COMPLEX (Repealed)
790.7220	PHENYLBUTAZONE (Repealed)
790.7221	PHENYLEPHRINE HYDROCHLORIDE (Repealed)

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790.7223	PHENYLEPHRINE HYDROCHLORIDE; PROMETHAZINE HYDROCHLORIDE (Repealed)
790.7229	PHENYTOIN SODIUM INJECTION (Repealed)
790.7245	PILOCARPINE HYDROCHLORIDE (Repealed)
790.7260	PIPERAZINE CITRATE (Repealed)
790.7263	PIROXICAM (Repealed)
790.7265	POLYETHYLENE GLYCOL 3350; POTASSIUM CHLORIDE; SODIUM BICARBONATE; SODIUM CHLORIDE; SODIUM SULFATE, ANHYDROUS (Repealed)
790.7272	POLYMYXIN B SULFATE (Repealed)
790.7278	POTASSIUM BICARBONATE (Repealed)
790.7280	POTASSIUM CHLORIDE (Repealed)
790.7284	POTASSIUM CHLORIDE; SODIUM CHLORIDE (Repealed)
790.7288	POTASSIUM GLUCONATE (Repealed)
790.7291	PRALDOXIME CHLORIDE (Repealed)
790.7294	PRAZEPAM (Repealed)
790.7296	PRAZOSIN HYDROCHLORIDE (Repealed)
790.7300	PREDNISOLONE ACETATE (Repealed)
790.7340	PREDNISOLONE ACETATE; SULFACETAMIDE SODIUM (Repealed)
790.7380	PREDNISOLONE SODIUM PHOSPHATE (Repealed)
790.7400	PREDNISON (Repealed)
790.7420	PRIMIDONE (Repealed)
790.7460	PROBENECID (Repealed)
790.7500	PROCAINAMIDE HYDROCHLORIDE (Repealed)
790.7510	PROCAINE HYDROCHLORIDE (Repealed)
790.7540	PROCHLORPERAZINE EDISYLATE (Repealed)
790.7580	PROCHLORPERAZINE MALEATE (Repealed)
790.7620	PROGESTERONE (Repealed)
790.7660	PROMAZINE HYDROCHLORIDE (Repealed)
790.7700	PROMETHAZINE HYDROCHLORIDE (Repealed)
790.7740	PROPANTHELINE BROMIDE (Repealed)
790.7780	PROPARACENE HYDROCHLORIDE (Repealed)
790.7820	PROPOXYPHENE HYDROCHLORIDE (Repealed)
790.7828	PROPRANOLOL HYDROCHLORIDE (Repealed)
790.7834	PROTAMINE SULFATE (Repealed)
790.7860	PSEUDOEPHEDRINE HYDROCHLORIDE; TRIPROLIDINE HYDROCHLORIDE (Repealed)
790.7900	PYRIDOSTIGMINE BROMIDE (Repealed)
790.7940	PYRIDOXINE HYDROCHLORIDE (Repealed)
790.7980	PYRILAMINE MALEATE (Repealed)
790.8015	QUINIDINE GLUCONATE (Repealed)
790.8020	QUINIDINE SULFATE (Repealed)
790.8030	QUININE SULFATE (Repealed)

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790.8060	RESERPINE (Repealed)
790.8100	RIFAMPIN (Repealed)
790.8106	RITODRINE HYDROCHLORIDE (Repealed)
790.8136	SECOBARBITAL SODIUM (Repealed)
790.8140	SELENIUM SULFIDE (Repealed)
790.8180	SILVER SULFADIAZINE (Repealed)
790.8220	SODIUM AMINOSALICYLATE (Repealed)
790.8232	SODIUM CHLORIDE (Repealed)
790.8244	SODIUM LACTATE (Repealed)
790.8248	SODIUM NITROPRUSSIDE (Repealed)
790.8260	SODIUM POLYSTYRENE SULFONATE (Repealed)
790.8290	SOYBEAN OIL (Repealed)
790.8300	SPIRONOLACTONE (Repealed)
790.8340	STREPTOMYCIN SULFATE (Repealed)
790.8378	SULFABENZAMIDE; SULFACETAMIDE; SULFATHIAZOLE (Repealed)
790.8380	SULFABENZAMIDE; SULFACETAMIDE; SULFATHIAZOLE; UREA (Repealed)
790.8420	SULFACETAMIDE SODIUM (Repealed)
790.8460	SULFADIAZINE (Repealed)
790.8500	SULFAMETHIZOLE (Repealed)
790.8540	SULFAMETHOXAZOLE (Repealed)
790.8580	SULFAMETHOXAZOLE; TRIMETHOPRIM (Repealed)
790.8590	SULFANILAMIDE (Repealed)
790.8620	SULFASALAZINE (Repealed)
790.8660	SULFINPYRAZONE (Repealed)
790.8700	SULFISOXAZOLE (Repealed)
790.8710	SULINDAC (Repealed)
790.8724	TEMAZEPAM (Repealed)
790.8727	TERBUTALINE SULFATE (Repealed)
790.8740	TESTOSTERONE CYPIONATE (Repealed)
790.8780	TESTOSTERONE ENANTHATE (Repealed)
790.8820	TESTOSTERONE PROPIONATE (Repealed)
790.8860	TETRACYCLINE (Repealed)
790.8900	TETRACYCLINE HYDROCHLORIDE (Repealed)
790.8940	THEOPHYLLINE (Repealed)
790.8980	THIAMINE HYDROCHLORIDE (Repealed)
790.9020	THIORIDAZINE HYDROCHLORIDE (Repealed)
790.9035	THIOXIXENE (Repealed)
790.9045	THIOXIXENE HYDROCHLORIDE (Repealed)
790.9048	TIMOLOL MALEATE (Repealed)
790.9050	TOBRAMYCIN SULFATE (Repealed)
790.9056	TOLAZAMIDE (Repealed)
790.9060	TOLBUTAMIDE (Repealed)
790.9070	TOLMETIN SODIUM (Repealed)

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790.9084	TRAZODONE HYDROCHLORIDE (Repealed)
790.9100	TRIAMCINOLONE ACETONIDE (Repealed)
790.9140	TRIFLUOPERAZINE HYDROCHLORIDE (Repealed)
790.9180	TRIHENXYPHENIDYL HYDROCHLORIDE (Repealed)
790.9220	TRIMETHAZINE TARTRATE (Repealed)
790.9260	TRIMETHOZINAMIDE HYDROCHLORIDE (Repealed)
790.9300	TRIMETHOPRIM (Repealed)
790.9320	TRIMIPRAMINE MALEATE (Repealed)
790.9340	TRIPLENNAMINE HYDROCHLORIDE (Repealed)
790.9380	TRIPROLIDINE HYDROCHLORIDE (Repealed)
790.9420	TRISULFAPYRIMIDINE (Repealed)
790.9460	TROPICAMIDE (Repealed)
790.9475	VALPROATE SODIUM (Repealed)
790.9478	VALPROIC ACID (Repealed)
790.9486	VANCOMYCIN HYDROCHLORIDE (Repealed)
790.9500	VERAPAMIL HYDROCHLORIDE (Repealed)
790.9520	VINBLASTINE SULFATE (Repealed)
790.9530	VINCISTINE SULFATE (Repealed)
790.9540	VITAMIN A (Repealed)
790.9580	VITAMIN A PALMITATE (Repealed)
790.9620	WATER FOR INJECTION, STERILE (Repealed)
790.9660	WATER FOR IRRIGATION, STERILE (Repealed)
790.9800	XYLOSE (Repealed)

AUTHORITY: Implementing and authorized by Section 3.14 of the Illinois Food, Drug and Cosmetic Act (Ill. Rev. Stat. 1991, ch. 56 1/2, par. 503.14) [410 ILCS 620/3.14] and Section 25 of the Pharmacy Practice Act (Ill. Rev. Stat. 1991, ch. 111, par. 4145) [225 ILCS 85/25].

SOURCE: Emergency amendment at 2 Ill. Reg. 18, p. 47, effective April 26, 1978, for a maximum of 150 days; amended at 2 Ill. Reg. 26, p. 150, effective July 1, 1978; emergency amendment at 2 Ill. Reg. 40, p. 98, effective October 1, 1978, for a maximum of 150 days; amended at 2 Ill. Reg. 51, p. 48, effective December 18, 1978; emergency amendment at 3 Ill. Reg. 2, p. 18, effective December 31, 1978, for a maximum of 150 days; emergency amendment at 3 Ill. Reg. 15, p. 147, effective April 1, 1979, for a maximum of 150 days; amended at 3 Ill. Reg. 27, p. 113, effective July 1, 1979; emergency amendment at 3 Ill. Reg. 32, p. 158, effective August 1, 1979, for a maximum of 150 days; amended at 3 Ill. Reg. 41, p. 178, effective October 8, 1979; emergency amendment at 4 Ill. Reg. 51, p. 147, effective December 12, 1980, for a maximum of 150 days; amended at 5 Ill. Reg. 3466, effective March 25, 1981; amended at 5 Ill. Reg. 7107, effective June 24, 1981; amended at 5 Ill. Reg. 9120, effective October 1, 1981; amended at 5 Ill. Reg. 14605, effective February 1, 1982; amended at 6 Ill. Reg. 6750, effective July 1, 1982; amended at 6 Ill. Reg. 11558, effective September 15, 1982; amended at 6 Ill. Reg. 15195, effective December 15, 1982; amended at 7 Ill. Reg. 7110, effective July 1, 1983; amended at 7 Ill. Reg. 13270, effective October 1, 1983; amended at 7 Ill. Reg. 16924, effective January 1, 1984; amended at 8 Ill. Reg. 2162, effective March 1, 1984; amended at 8 Ill. Reg. 8513, effective July 1, 1984; codified at 8 Ill.

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Reg. 13402; amended at 8 Ill. Reg. 22108, effective November 1, 1984; amended at 9 Ill. Reg. 4071, effective April 1, 1985; amended at 9 Ill. Reg. 6816, effective May 1, 1985; amended at 10 Ill. Reg. 253, effective January 1, 1986; amended at 10 Ill. Reg. 8814, effective May 15, 1986; amended at 11 Ill. Reg. 3565, effective February 23, 1987; amended at 11 Ill. Reg. 9223, effective May 15, 1987; amended at 11 Ill. Reg. 14382, effective August 15, 1987; amended at 12 Ill. Reg. 1823, effective January 1, 1988; emergency amendment at 12 Ill. Reg. 1984, effective January 1, 1988, for a maximum of 150 days; emergency amendment at 12 Ill. Reg. 7743, effective April 15, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 9153, effective May 13, 1988; amended 12 Ill. Reg. 10133, effective May 31, 1988, emergency amendment at 12 Ill. Reg. 10745, effective June 2, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 12846, effective July 29, 1988; emergency amendment at 12 Ill. Reg. 13255, effective August 5, 1988, for a maximum of 150 days; emergency expired January 2, 1989; amended at 12 Ill. Reg. 15101, effective September 16, 1988; emergency amendment at 12 Ill. Reg. 856, effective January 6, 1989; emergency amendment at 13 Ill. Reg. 3108, effective February 28, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 8890, effective May 26, 1989, and January 1, 1990; amended at 13 Ill. Reg. 11717, effective July 14, 1989; corrected at 13 Ill. Reg. 12909; emergency amendment at 13 Ill. Reg. 12990, effective August 1, 1989, for a maximum of 150 days; corrected at 13 Ill. Reg. 14477; emergency amendment at 13 Ill. Reg. 17101, effective October 13, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 19770, effective December 8, 1989; emergency amendment at 14 Ill. Reg. 1505 effective January 12, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 3184, effective February 16, 1990; emergency amendment at 14 Ill. Reg. 4620, effective March 9, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 8154, effective May 11, 1990; emergency amendment at 14 Ill. Reg. 9556, effective June 1, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 11988, effective July 13, 1990; emergency amendment at 14 Ill. Reg. 13325, effective August 10, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 17298, effective October 5, 1990; emergency amendment at 14 Ill. Reg. 18588, effective November 9, 1990; emergency expired April 8, 1991; amended at 14 Ill. Reg. 20755, effective December 21, 1990; emergency amendment at 15 Ill. Reg. 3537, effective March 8, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 6566, effective April 19, 1991; emergency amendment at 15 Ill. Reg. 11194, effective July 19, 1991; for a maximum of 150 days; amended at 15 Ill. Reg. 11791, effective August 2, 1991; emergency amendment at 15 Ill. Reg. 18697, 16484, effective October 25, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 18697, effective December 13, 1991; emergency amendment at 16 Ill. Reg. 4899, effective March 14, 1992; amended at 16 Ill. Reg. 5941, effective March 24, 1992; emergency amendment at 16 Ill. Reg. 8571, effective May 15, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 12913, effective August 10, 1992; amended at 16 Ill. Reg. 16019, effective September 30, 1992; emergency amendment at 16 Ill. Reg. 17781, effective November 9, 1992, for a maximum of 150 days; emergency expired April 8, 1993; emergency amendment at 17 Ill. Reg. 7283, effective May 7, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 15916, effective September 20, 1993; emergency repealer at 18 Ill. Reg. _____, effective February 22, 1994, for a maximum of 150 days.

SUBPART A: GENERAL PROVISIONS

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Section 790.20 Introduction
EMERGENCY

- a) The Illinois Food, Drug and Cosmetic Act (Ill. Rev. Stat. 1987, ch. 56 1/2, par. 503.14) [410 ILCS 620/3.14] allows interchange of different brands or nonbrands of the same generic drug entity for a drug product prescribed by a specific trade name. Products selected for interchange must be pharmaceutically equivalent to the prescribed product and must be listed in a positive drug product formulary known as the Illinois Formulary which has been developed, maintained and issued by the Illinois Department of Public Health (hereinafter referred to as the "Department"). The practice of selecting an equivalent drug product from the Illinois Formulary to dispense instead of the trade name product prescribed is known as Drug Product Selection (DPS).

- b) The initial issue of the Illinois Formulary for use in Drug Product Selection became effective on July 1, 1978. Periodic updates to the Illinois Formulary will be distributed by the Department of Public Health. Single copies of the Illinois Formulary shall be provided to all licensed pharmacies with Illinois addresses. Upon request, single copies of the Illinois Formulary will be provided, at no charge, to licensed prescribers, pharmacists practicing their profession in Illinois, to pharmacists seeking reciprocity, students enrolled in a pharmacy curriculum at the University of Illinois at Chicago at Chicago, College of Pharmacy, the Chicago College of Pharmacy, the St. Louis College of Pharmacy, students enrolled out-of-state in a college of pharmacy who seek a pharmacist licensure in the State of Illinois, or students enrolled in a pharmacy technician program.

- c) The Department shall make available to other interested parties a subscription to the Illinois Formulary and its revisions at a fee of \$50.00 per year. All subscription fees collected by the Department shall be deposited into the Food and Drug Safety Fund.

Consideration of Drug Products for Inclusion in the Illinois Formulary

- a) Drug products for inclusion in the Illinois Formulary shall be approved and recommended to the Director, Illinois Department of Public Health, by a Technical Advisory Council composed of seven members, each of who has extensive experience in pharmaceutical affairs. Products for Council consideration shall be researched and presented by Departmental staff following consideration of recommendations by the Federal Food and Drug Administration (FDA), of recognized drug reference sources, of published research, and of qualified consultants.

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- b) No product shall be considered for inclusion in the Illinois Formulary unless each individual dosage form, dosage strength and manufacturer has been recommended for drug product selection use by the FDA. Each product considered must be verified by the FDA as being marketed under currently approved drug applications, as meeting required manufacturing standards and chemical identity standards, and as being cleared of any issues involving the bioequivalence or bioavailability of the product. Prior to being sanctioned for DPS use, the product must pass FDA criteria specific for DPS approval which may be more stringent than that required for general marketing approval.

- c) Products in generic entities (as described in Section 790.100 of this Part) never previously reviewed in any manner shall be ineligible for consideration at Technical Advisory Council meetings if the products' FDA approval date is 30 or fewer days prior to the scheduled Technical Advisory Council meeting. Such entities initial review shall be deferred to the next scheduled Technical Advisory Council meeting.

- d) Manufacturers of products in generic entities never previously reviewed in any manner, or items under further consideration by the Technical Advisory Council, for whatever reason, shall comply with the following criteria to be allowed to address the Council:

- 1) Eight copies of testimony and eight copies of any and all data upon which comment or reference to may be made, whether published or unpublished, shall be submitted, in writing, to the following address no later than 50 calendar days prior to the regularly scheduled quarterly meeting of the Technical Advisory Council.

Administrator, Drug Product Selection Program
Illinois Department of Public Health
Office of Health Protection
Division of Food, Drugs and Dairies
525 W. Jefferson Street
Springfield, Illinois 62761

- 2) The Department shall notify all other manufacturers of products within a specific generic entity that a petition for review has been received within the time frame specified in this Section. Such manufacturers shall provide 8 copies of testimony and eight copies of any and all data upon which comment or reference to may be made, whether published or unpublished, in writing, to the Department within 30 days of the regularly scheduled meeting should they wish to make presentation on the specific issue at the Council meeting. Eight copies

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of any and all rebuttal comments from any concerned manufacturer shall be submitted, in writing, to the Department within 14 days of the regularly scheduled meeting, should a company wish to respond to its competitor's submission.

- 3) Each manufacturer shall be limited to a 20 minute presentation, irrespective of their number of speakers. Additional time shall be available to answer specific questions of the Technical Advisory Council members, if necessary.
- e) Failure to comply with these criteria shall result in the exclusion of the speaker(s) from the agenda.
- f) Exclusive indications and unique product packaging, whether patented or unpatented, do not constitute criteria for inclusion of a drug entity in the Illinois Formulary.

Section 790.60 Additional Criteria
EMERGENCY

Additional criteria may be adopted as needed by the Department upon the recommendation of the Technical Advisory Council to further define the parameters for drug product inclusion. Individual exceptions to any criteria may be made upon a majority vote of the assembled Council members and such exceptions must be noted in the Illinois Formulary.

Section 790.80 Quality Listing
EMERGENCY

- a) The Illinois Formulary is a quality listing of generically equivalent drug products approved for marketing and is based upon the criteria as found in these Rules and Regulations. The listing is not affected by costs or by current or pending litigation against a particular drug product. As an aid to users of the formulary, an informational footnote will be placed with an entity listing whenever the Department receives substantive evidence of litigation involving the product(s). Products will be deleted from the formulary listing whenever FDA regulatory processes or other legal action results in a loss of the product's marketing approval or availability.
- b) The names of application holders who are known to be solely repackers will be enclosed in parentheses for the information of the practitioner.
- c) Products discontinued from marketing or products which have their approval withdrawn for reasons other than safety and efficacy, will be noted by the symbol "@" preceding the dosage form. This symbol

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designates their non-marketed status and notifies practitioners that the specific manufacturer's product may be in short supply. The "@" notation does not change the drug product selection status of the drug entity. Products approved and listed for interchange may be used until their supply is exhausted.

Section 790.100 Generic Drug Entity Headings
EMERGENCY

The formulary consists of generic drug entity headings in alphabetical order. Within the entity grouping is indicated the individual product's marketed name, dosage form and dosage strength. The manufacturer listed is the firm holding the FDA approved drug application for the product. Listed products remain approved for DPS use when distributed under the label of another manufacturer.

Section 790.120 Comments and Specific Administration
EMERGENCY

Comments and specific information regarding drug products either listed or under consideration for formulary inclusion will be accepted by the Department at any time for due consideration. Inquiries or comments should be directed to:

Administrator, Drug Product Selection Program
Illinois Department of Public Health
Office of Health Protection
Division of Food, Drugs and Dairies
525 West Jefferson Street
Springfield, Illinois 62761

Section 790.140 Requests for Additional Copies
EMERGENCY

Requests to receive additional copies of the formulary or for changes to the recipient mailing list should be sent to the address in Section 790.120.

Section 790.160 Prescription Use of Drug Products
EMERGENCY

Drug products included shall be primarily for prescription use outside of the inpatient institutional setting. Excluded are nonprescription drugs, diagnostic aids, nutritional supplements and medical devices.

Section 790.180 FDA Drug Product Approval and Recommendation
EMERGENCY

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Drug products included shall have been approved and recommended for DPS use by the FDA and approved for listing in a publication of approved drug products distributed by the FDA for use in state programs. All products must have either a New Drug Application (NDA), Abbreviated New Drug Application (ANDA), or Antibiotic Form 5 or 6 Application approved by the FDA under the provisions of Sections 505 and 507 of the Federal Food, Drug and Cosmetic Act (21 U.S.C.A. 301 et seq.). All products have been certified by the FDA as safe and effective for their labeled use, meet current compendial and Good Manufacturing Practices (GMP) requirements, and have met the applicable bioavailability and bioequivalence criteria of the FDA.

Section 790.200 Availability of Drug Products; Pharmaceutical Equivalence EMERGENCY

Drug products included must be available from more than one approved manufacturing source unless otherwise noted. Drug products listed must be pharmaceutically equivalent to at least one other drug product under the same entity listing. Drug products are pharmaceutically equivalent if they contain the same active ingredients, are identical in dosage form and route of administration, are formulated to meet the same or comparable standards and vary in labeled dosage strength by no more than 1%.

Section 790.220 Single Source Drug Products Exclusion EMERGENCY

Single source drug products which are available only under a single brand name label shall be excluded. Products which have a single source manufacturer, but which may be distributed under multiple labels are listed with a warning for pharmacists to ascertain that the product selected was produced by the approved manufacturer.

Section 790.240 Criteria for Exclusion of Drug Products EMERGENCY

Drug products of the following dosage forms for which different brands are not necessarily pharmaceutically and therapeutically equivalent shall be excluded:

- a) Enteric coated tablets
- b) Injectable suspensions, other than antibiotics
- c) Suppositories containing active ingredients for which systemic absorption is necessary for therapeutic activity
- d) Different delivery systems for aerosol and nebulizer drugs

Section 790.260 Inclusion of Controlled Substances EMERGENCY

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Controlled substances listed in Schedule I of the Illinois Controlled Substances Act, (Ill. Rev. Stat., 1983, ch. 56 1-2, par. 1100), shall be excluded. Products in Schedules II, III, IV and V are included provided they meet all other criteria as set forth in subpart A of this Part.

Section 790.280 Equivalence of Products Requirements EMERGENCY

All equivalent products selected by the pharmacist for interchange use must have the product's dosage form, the dosage strength, and the manufacturer listed in the Illinois Formulary as revised. Drug products recommended by the Technical Advisory Council for inclusion in a formulary revision must not be used for drug product selection until the effective date of that revision.

Section 790.300 Selection of Equivalent Drug Products EMERGENCY

Even though a prescribed brand name drug product is unlisted, pharmacists may select an equivalent drug product to dispense under Section 790.280 as long as the corresponding generic drug entity with pharmaceutically equivalent drug products are listed in the Illinois Formulary as revised.

Section 790.320 Transfer of Prescription Records EMERGENCY

Pharmacists shall be required to designate the prescriber's original intent concerning drug product selection on every prescription record transferred to another pharmacy, irrespective of the method of transfer. The receiving pharmacy shall record the prescriber's drug product selection intent on the original prescription record of the transferred prescription.

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1) The Heading of the Part:

The Illinois Formulary for the Drug Product Selection Program

2) Code Citation:

77 Ill. Adm. Code 790

3) Section Numbers:Emergency Action:

790.10	New Section
790.20	New Section
790.40	New Section
790.50	New Section
790.60	New Section
790.65	New Section
790.80	New Section

4) Statutory Authority:

Implementing and authorized by Section 3.14 of the Illinois Food, Drug and Cosmetic Act (Ill. Rev. Stat. 1991, ch. 56 1/2, par. 503.14) (410 ILCS 620/3.14) and Section 25 of the Pharmacy Practice Act (Ill. Rev. Stat. 1991, ch. 111, par. 4145) (225 ILCS 85/25).

5) Effective Date of Emergency Rules:

February 22, 1994

6) If this Emergency Rule is to Expire Before the End of the 150-Day Period, Please Specify the Date on Which it is to Expire:

Not Applicable

7) Date Filed in Agency's Principal Office:

February 22, 1994

8) Reason for Emergency:

The Department is proceeding with this rulemaking as an emergency because of the potential adverse economic impact its delay would have upon the prescription consuming public and the third-party prescription reimbursement sector of the health care economy. This rulemaking will make savings available to individuals paying for prescription medications on an out-of-pocket basis and those insurance, employer and pension programs that pay for their beneficiaries'

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prescription medications. The biggest potential recipient of such savings is the Department of Public Aid, which over time will be able to establish generic reimbursement limits for several additional pharmaceuticals now currently limited to premium brand name prices.

9) A Complete Description of the Subjects and Issues Involved:

This rulemaking clarifies and codifies the Department's full authority, as specified in the Illinois Food, Drug and Cosmetic Act, to determine the equivalency of drug products irrespective of the products' status with the Federal Food and Drug Administration (FDA). The rule implements the process whereby the Department may review pharmaceuticals not subject to an approved FDA new drug application. Such products may include "grandfathered" drugs (those marketed before the implementation of the 1938 federal Food, Drug and Cosmetic Act) and DESI drugs (products subject to the Drug Efficacy Study Implementation, a federally, statutorily mandated review of products originally marketed between 1938 and 1962, in order to determine the products' safety and efficacy). Pharmaceuticals marketed under federal provisions allowing "identical, related or similar" ("IRS") dosage forms are also available for equivalency determinations. These emergency rules replace the Department's current rules at Part 600, which set the minimum qualifications for personnel employed by local health departments.

10) Are There Any Proposed Amendments Pending on this Part?Yes _____ No ✓11) Statement of Statewide Policy Objectives:

These rules will not require any new expenditures by units of local government.

12) Information and Questions Regarding these Emergency Rules shall be directed to:

Gail M. DeVito
535 West Jefferson, Fifth Floor
Springfield, Illinois 62761
217/782 6187

The full text of the Emergency Rules begins on the next page.

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TITLE 77: PUBLIC HEALTH

CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER m: FOOD, DRUGS AND COSMETICS

PART 790

THE ILLINOIS FORMULARY FOR THE DRUG PRODUCT SELECTION PROGRAM

SECTION

790.10 Definitions

EMERGENCY

790.20 General Provisions

EMERGENCY

790.40 Consideration of Drug Products for Inclusion
EMERGENCY in the Illinois Formulary

790.50 Director's Decisions as Final Orders

EMERGENCY

790.60 Bioequivalence Criteria

EMERGENCY

790.65 Statistical Criteria

EMERGENCY

790.80 Deletion of Drug Products

EMERGENCY

AUTHORITY: Implementing and authorized by Section 3.14 of the Illinois Food, Drug and Cosmetic Act (Ill. Rev. Stat. 1991, ch. 56 1/2, par. 503.14) [410 ILCS 620/3.14] and Section 25 of the Pharmacy Practice Act (Ill. Rev. Stat. 1991, ch. 111, par. 4145) [225 ILCS 85/25].

SOURCE: Emergency amendment at 2 Ill. Reg. 18, p. 47, effective April 26, 1978, for a maximum of 150 days; amended at 2 Ill. Reg. 26, p. 150, effective July 1, 1978; emergency amendment at 2 Ill. Reg. 40, p. 98, effective October 1, 1978, for a maximum of 150 days; amended at 2 Ill. Reg. 51, p. 48, effective December 18, 1978; emergency amendment at 3 Ill. Reg. 2, p. 18, effective December 31, 1978, for a maximum of 150 days; emergency amendment at 3 Ill. Reg. 15, p. 147, effective April 1, 1979, for a maximum of 150 days; amended at 3 Ill. Reg. 27, p. 113, effective July 1, 1979; emergency amendment at 3 Ill. Reg. 32, p. 158, effective August 1, 1979, for a maximum of 150 days; amended at 3 Ill. Reg. 41, p. 178, effective October 8, 1979; emergency amendment at 4 Ill. Reg. 51, p. 147, effective December 12, 1980, for a maximum of 150 days; amended at 5 Ill. Reg. 3466, effective March 25, 1981; amended at 5 Ill. Reg. 7107, effective June 24, 1981; amended at 5 Ill. Reg. 9120, effective October 1, 1981; amended at 5 Ill. Reg. 14605, effective February 1, 1982; amended at 6 Ill. Reg. 6750, effective July 1, 1982; amended at 6 Ill. Reg. 11558, effective September 15, 1982; amended at 6 Ill. Reg. 15195, effective December 15, 1982; amended at 7 Ill. Reg. 7110, effective July 1, 1983; amended at 7 Ill. Reg. 13270, effective October 1, 1983; amended at 7 Ill. Reg. 16924, effective January 1, 1984; amended at 8 Ill. Reg. 2162, effective March 1, 1984; amended at 8 Ill. Reg. 8513, effective July 1, 1984; codified at 8 Ill. Reg. 13402; amended at 8 Ill. Reg. 22108, effective November 1, 1984; amended at 9 Ill. Reg.

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4071, effective April 1, 1985; amended at 9 Ill. Reg. 6816, effective May 1, 1985; amended at 10 Ill. Reg. 253, effective January 1, 1986; amended at 10 Ill. Reg. 8814, effective May 15, 1986; amended at 11 Ill. Reg. 3565, effective February 23, 1987; amended at 11 Ill. Reg. 9223, effective May 15, 1987; amended at 11 Ill. Reg. 14382, effective August 15, 1987; amended at 12 Ill. Reg. 1823, effective January 1, 1988; emergency amendment at 12 Ill. Reg. 1984, effective January 1, 1988, for a maximum of 150 days; emergency amendment at 12 Ill. Reg. 7743, effective April 15, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 9153, effective May 13, 1988; amended at 12 Ill. Reg. 10133, effective May 31, 1988, emergency amendment at 12 Ill. Reg. 10745, effective June 2, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 12846, effective July 29, 1988; emergency amendment at 12 Ill. Reg. 13255, effective August 5, 1988, for a maximum of 150 days; emergency expired January 2, 1989; amended at 12 Ill. Reg. 15101, effective September 16, 1988; emergency amendment at 12 Ill. Reg. 16937, effective October 7, 1988, for a maximum of 150 days; amended at 13 Ill. Reg. 856, effective January 6, 1989; emergency amendment at 13 Ill. Reg. 3108, effective February 28, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 8890, effective May 26, 1989, and January 1, 1990; amended at 13 Ill. Reg. 11717, effective July 14, 1989; corrected at 13 Ill. Reg. 12909; emergency amendment at 13 Ill. Reg. 12990, effective August 1, 1989, for a maximum of 150 days; corrected at 13 Ill. Reg. 14477; emergency amendment at 13 Ill. Reg. 17101, effective October 13, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 19770, effective December 8, 1989; emergency amendment at 14 Ill. Reg. 1505 effective January 12, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 3184, effective February 16, 1990; emergency amendment at 14 Ill. Reg. 4620, effective March 9, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 8154, effective May 11, 1990; emergency amendment at 14 Ill. Reg. 9556, effective June 1, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 11988, effective July 13, 1990; emergency amendment at 14 Ill. Reg. 13325, effective August 10, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 17298, effective October 5, 1990; emergency amendment at 14 Ill. Reg. 18588, effective November 9, 1990; emergency expired April 8, 1991; amended at 14 Ill. Reg. 20755, effective December 21, 1990; emergency amendment at 15 Ill. Reg. 3537, effective March 8, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 6566, effective April 19, 1991; emergency amendment at 15 Ill. Reg. 11194, effective July 19, 1991; for a maximum of 150 days; amended at 15 Ill. Reg. 11791, effective August 2, 1991; emergency amendment at 15 Ill. Reg. 16484, effective October 25, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 18697, effective December 13, 1991; emergency amendment at 16 Ill. Reg. 4899, effective March 14, 1992; amended at 16 Ill. Reg. 5941, effective March 24, 1992; emergency amendment at 16 Ill. Reg. 8571, effective May 15, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 12913, effective August 10, 1992; amended at 16 Ill. Reg. 16019, effective September 30, 1992; emergency amendment at 16 Ill. Reg. 17781, effective November 9, 1992, for a maximum of 150 days; emergency expired April 8, 1993; emergency amendment at 17 Ill. Reg. 7283, effective May 7, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 15916, effective September 20, 1993; Part repealed, new Part adopted by emergency action at 18 Ill. Reg. _____, effective February 22, 1994, for a maximum of 150 days.

NOTE: Capitalization denotes statutory language.

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Section 790.10
EMERGENCY Definitions

"Act" means the Illinois Food, Drug and Cosmetic Act (Ill. Rev. Stat. 1991, ch. 56 1/2, par. 501 et seq.) [410 ILCS 620].

"Bioavailability" means the extent and rate of absorption from a dosage form as reflected by the time-concentration curve of the administered drug in the systemic circulation.

"Bioequivalents" means chemical equivalents which, when administered to the same individuals in the same dosage regimen, will result in comparable bioavailability.

"Brand name" means the proprietary name assigned to a drug product by the manufacturer, distributor or labeler thereof.

"Chemical equivalents" means those drug products that contain the same amounts of the same therapeutically active moieties in the same dosage forms and that meet present compendial standards.

"Council" means the Technical Advisory Council for the Drug Product Selection Program.

"Department" means the Illinois Department of Public Health.

"Director" means the Director of the Illinois Department of Public Health or his designee.

"Dosage form" means the physical formulation or medium in which the product is intended, manufactured and made available for use, including but not limited to: tablets, capsules, powders, oral solutions, oral suspensions, aerosols, inhalers, injectable solutions, injectable suspensions, gels, lotions, creams, ointments, topical solutions, inserts, transdermals and suppositories, and the particular form of the above which utilizes a specific technology or mechanism to control, enhance or direct the release, targeting, systemic absorption or other delivery of a dosage regimen in the body.

"Drug product" means a dosage form containing one or more active therapeutic moieties along with other substances included during the manufacturing process.

"Drug Product Selection" means the act of selecting the source of supply of a drug product in a specified dosage form in accordance with section 3.14 of the Illinois Food, Drug and Cosmetic Act and Section 25 of the Pharmacy Practice Act of 1987.

"Established name" with respect to a drug or ingredient thereof, means:

the applicable official name designated pursuant to the Federal Food, Drug and Cosmetic Act (Title 21, USC 301 et seq.); or

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if there is no such official name and such drug or ingredient is recognized in an official compendium, then the official title thereof in such compendium, except that where a drug or ingredient is recognized in the United States Pharmacopoeia-National Formulary (USP-NF) and in the Homeopathic Pharmacopoeia under different titles, the official title used in the United States Pharmacopoeia-National Formulary shall apply unless it is labeled and offered for sale as a homeopathic drug, in which case the official title used in the Homeopathic Pharmacopoeia shall apply; or

if neither of the above is applicable, then the common or usual name, if any, of such drug or ingredient.

"Illinois Formulary" means the positive drug formulary listing which is developed, maintained, and issued by the Department under which drug product selection within a generic class, or selection of specific products for those prescribed, is permitted pursuant to the Act.

"Innovator product" means a drug product, usually bearing a brand name, approved for marketing via a fully approved Food and Drug Administration (FDA) new drug application or antibiotic form 5.

"Interchangeable drug products" means pharmaceutical equivalents, bioequivalents or other dosage forms that are determined to be therapeutic equivalents by the Technical Advisory Council.

"Legally authorized representative" means a parent or guardian of a person under age 18 years, or a guardian or other person designated as an agent of a person over age 18 years.

"Legend drug" means a pharmaceutical product required under federal law to bear on its label the statement "Caution: Federal law prohibits dispensing without prescription."

"Moiety" means the portion of a drug product responsible for its therapeutic activity.

"Molar dose" means the dose of a drug based on its weight in grams or portions thereof.

"Pharmaceutical alternatives" means drug products which contain the same therapeutic moiety, but are different salts, esters, or complexes of the moiety, or are different dosage forms or strengths.

"Pharmaceutical equivalents" means those drug products that contain the same concentration or strength of the same therapeutically active ingredients in the same dosage form and route of administration, that meet standards established by either the United States Food and Drug Administration (FDA) or the United States Pharmacopoeial Convention, Inc. (USP-NF). Pharmaceutical equivalents may differ in characteristics such as shape, scoring configuration, packaging, excipients (including, but not limited to, colors, flavors and preservatives), expiration time and, within limits, labeling required by the FDA or USP-NF.

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"Pharmacist" means a person licensed to practice pharmacy pursuant to the Pharmacy Practice Act of 1987 (Ill. Rev. Stat. 1991, ch. 111, par. 4121 et seq.) (225 ILCS 85).

"Prescription" means an order for drugs or combinations or mixtures thereof, written or signed by a physician licensed to practice medicine in all of its branches, or a dentist or podiatrist within the scope of their authority to practice, and includes orders for drugs or medicines or combinations or mixtures thereof transmitted to pharmacists through word of mouth, telephone, electronic mail, facsimile or other means of communication by a physician licensed to practice medicine in all of its branches, or a dentist or podiatrist within the scope of their authority to practice.

"Present compendial standards" means the official standards for drug excipients and drug products listed in the latest revision of the United States Pharmacopoeia-National Formulary (USP-NF).

"Reference drug product" means the product which may be adopted by the Council as the standard for other chemically equivalent drugs in terms of testing for therapeutic equivalence.

"Test drug product" means the drug product selected by a pharmaceutical manufacturer as the product for comparison of bioequivalence data.

"Therapeutic equivalents" means chemical and pharmaceutical equivalents which, when administered to the same individuals in the same dosage regimen, will provide essentially the same efficacy and toxicity as their respective reference drug products.

Section 790.20 General Provisions
EMERGENCY

a) Section 3.14 of the Act allows interchange of different brands or nonbrands of the same generic drug for a drug product prescribed by a specific brand name pursuant to a prescription or medication order issued outside of the inpatient hospital setting. Products selected for interchange must be pharmaceutically equivalent to the prescribed product and must be listed in a positive drug product formulary known as the Illinois Formulary for the Drug Product Selection Program, which has been developed, maintained and issued by the Illinois Department of Public Health (hereinafter referred to as the "Department"). The pharmacist's practice of selecting an equivalent drug product from the Illinois Formulary to dispense instead of the prescribed brand name drug product is known as Drug Product Selection (DPS).

b) The Illinois Formulary consists of chemical equivalents in alphabetical order. Within the grouping is indicated the individual product's marketed name, dosage form, dosage strength and manufacturer. The manufacturer listed is the firm holding the FDA approved drug application for the product, when applicable. Listed products remain approved for DPS use when distributed

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under the generic name of the same manufacturer or the brand or generic name label of another distributor.

c) Updates to the Illinois Formulary are published and distributed by the Department. Single copies of the Illinois Formulary shall be provided to all licensed pharmacies with Illinois addresses. Upon request, single copies of the Illinois Formulary will be provided, at no charge, to licensed prescribers, licensed pharmacists, pharmacists seeking reciprocity, students enrolled in a pharmacy curriculum at the University of Illinois at Chicago at Chicago, College of Pharmacy, the Chicago College of Pharmacy of Midwestern University or the St. Louis College of Pharmacy, students enrolled out-of-state in a college of pharmacy who seek a pharmacist licensure in the State of Illinois, or students enrolled in an Illinois pharmacy technician program. The Department shall make available to other interested parties a subscription to the Illinois Formulary and its revisions at a fee of \$50.00 per year per copy. All subscription fees collected by the Department shall be deposited into the Food and Drug Safety Fund.

d) The Drug Product Selection Program applies whenever an outpatient or his/her representative presents a prescription for a legend drug to an outpatient pharmacy or when the outpatient pharmacy receives an oral prescription order from the prescriber to dispense a drug product to an outpatient. Drug Product Selection shall only occur under the following circumstances:

- 1) The prescriber has not blocked Drug Product Selection either orally or by personally checking or marking beside the "May Not Substitute" choice on a compliant prescription form, or has otherwise indicated a phrase such as "Brand Medically Necessary" in his or her own personal handwriting on the prescription, and;
 - 2) The drug has a therapeutic equivalent listed in the current Illinois Formulary, and;
 - 3) The informed patient or his/her legally authorized representative has agreed to accept a therapeutically equivalent product.
 - 4) No third-party payor may order a pharmacist to interchange a prescribed brand name drug product contrary to the provisions of the Act or this Part.
- e) The Illinois Formulary is a listing of chemically equivalent drug products and is based upon the criteria in this Part. The listing is not affected by costs or by current or pending litigation against a particular drug product.

- 1) The names of application holders who are known to be repackers only will be enclosed in parentheses for the information of the practitioner.
- 2) Products discontinued from marketing or products which have their approval

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withdrawn for reasons other than safety and efficacy, will be noted by the symbol "@" preceding the dosage form. This symbol designates their non-marketed status and notifies practitioners that the specific manufacturer's product may be in short supply. The "@" notation does not change the drug product selection status of the drug entity. Products approved and listed for interchange may be used until their supply is exhausted.

- 3) Single source drugs (products which are available only under a single brand name label) shall be excluded. Products which have a single source manufacturer, but which may be distributed under multiple labels, are listed with a warning for pharmacists to ascertain that the product selected was produced by the approved manufacturer.
- 4) Drug products included shall be for prescription use. Excluded are nonprescription drugs, diagnostic aids, nutritional supplements, and medical devices.
- f) Each equivalent product selected by a pharmacist for interchange use must have the product's dosage form, the dosage strength as applicable, and the manufacturer listed in the current Illinois Formulary.
- g) Even though a prescribed brand name drug product is unlisted, a pharmacist may select an equivalent drug product to dispense as long as the corresponding generic drug entity with pharmaceutically equivalent drug products are listed in the current Illinois Formulary.
- h) Pharmacists shall designate the prescriber's original intent concerning drug product selection on each prescription record transferred to another pharmacy, irrespective of the method of transfer. The receiving pharmacy shall record the prescriber's drug product selection intent on the original prescription record of the transferred prescription.

Section 790.40 Consideration of Drug Products for Inclusion in the EMERGENCY Illinois Formulary

- a) Drug products to be considered for inclusion in the Illinois Formulary shall be reviewed by the Department for compliance with this Part, and if found to be in compliance with this Part, shall be presented for review by the Technical Advisory Council.
 - 1) The Department shall receive submissions of information from manufacturers, shall determine whether such submissions are complete, in accordance with this Part and shall notify the submitters of any additional information necessary to render the submission complete.
 - 2) Submissions deemed by the Department to be incomplete or otherwise not in

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compliance with this Part shall not be presented to the Technical Advisory Council.

- b) No product shall be included in the Illinois Formulary unless each individual dosage form, dosage strength and manufacturer has been recommended for drug product selection use by the FDA, unless the Council has determined that two or more dosage forms and strengths are therapeutic equivalents. Each product considered must meet required FDA manufacturing standards and compendial identity standards, and be cleared of any issues involving the bioequivalence or bioavailability of the product. Products listed in the FDA publication entitled "Approved Drug Products with Therapeutic Equivalence Evaluations" (also known as the "Orange Book") and carrying an "A" rating shall be considered for inclusion in the Illinois Formulary. Prescription drug products with a "B" rating and those prescription drug products not listed in the "Orange Book" may also be considered for inclusion in the Illinois Formulary.
 - 1) All products must have either a New Drug Application (NDA), paper NDA, Abbreviated New Drug Application (ANDA), or Antibiotic Form 5 or 6 Application approved by the FDA under the provisions of Section 505 and 507 of the Federal Food, Drug and Cosmetic Act (21 USCA 301 et seq.) unless such approval is not required under federal law for the product's marketing. Where required under federal law, all products shall have been certified by the FDA as safe and effective for their labeled use, shall meet current compendial and Current Good Manufacturing Practices (CGMP) requirements as adopted pursuant to Section 21(i) of the Act, and shall have met applicable bioavailability and bioequivalence criteria.
 - 2) Controlled substances listed in Schedule I of the Illinois Controlled Substances Act (Ill. Rev. Stat. 1991, ch. 56 1/2, par. 1204) [720 ILCS 570/204] shall be excluded. Products in Schedules II, III, IV, and V of the Illinois Controlled Substances Act (Ill. Rev. Stat. 1991, ch. 56 1/2, par. 1206, 1208, 1210, and 1212) [720 ILCS 570/206, 208, 210, and 212] may be included if they meet all other requirements of this Part.
 - c) Any chemical equivalent not previously reviewed in any manner shall be ineligible for consideration at Technical Advisory Council meetings if the product's FDA approval date is 50 or fewer days prior to the scheduled Technical Advisory Council meeting. Such chemical equivalent's initial review shall be deferred to the next scheduled Technical Advisory Council meeting.
 - d) Manufacturers of chemical equivalents never previously reviewed in any manner, or items under further consideration by the Technical Advisory Council, for whatever reason, shall comply with the following criteria to be allowed to address the Council:
 - 1) Eight copies of testimony and eight copies of any and all data upon which

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comment or reference to may be made, whether published or unpublished, shall be submitted, in writing, to the following address no later than 50 calendar days prior to the regularly scheduled quarterly meeting of the Technical Advisory Council.

Illinois Department of Public Health
Office of Health Protection
Division of Food, Drugs and Dairies
525 West Jefferson Street
Springfield, Illinois 62761

- 2) The manufacturer shall also submit a "purged" copy of the testimony and data referenced in subsection (d)(1) of this Section which may be made available to other interested parties by the Department in compliance with the Freedom of Information Act (Ill. Rev. Stat. 1991, ch. 116, pars. 201 et seq.) [5 ILCS 140]. The "purged" copy shall be prepared to block review of information considered to be an invasion of personal privacy, a "trade secret" or any other exemption allowed in accordance with Section 7 of the Freedom of Information Act. (Such exemptions commonly are limited to names of patients or subjects in bioequivalence or clinical studies and lot identification numbers of products involved in such studies.) The Department shall determine if manufacturer-identified exempted information complies with Section 7 of the Freedom of Information Act.
- 3) The Department shall notify all other manufacturers of products within a specific generic entity that a petition for review has been received within the time frame specified in this Section. Such manufacturers shall provide eight copies of testimony and eight copies of any and all data upon which comment or reference to may be made, whether published or unpublished, in writing, to the Department within 30 days of the regularly scheduled meeting should they wish to make presentation on the specific issue at the Council meeting. Eight copies of any and all rebuttal comments from any concerned manufacturer shall be submitted, in writing, to the Department within 14 days of the regularly scheduled meeting, should a company wish to respond to its competitor's submission.
- 4) Each manufacturer shall be limited to a 20 minute presentation, irrespective of their number of speakers. Additional time shall be available to answer specific questions of the Technical Advisory Council members, if necessary.
- e) Failure to comply with these criteria shall result in the exclusion of the speaker(s) from the agenda.
- f) Exclusive indications and unique product packaging, whether patented or unpatented, do not constitute criteria for inclusion of a chemical entity in the Illinois Formulary.

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- g) There shall be no ex-parte communications between representatives or agents of pharmaceutical corporations, whether directly employed or acting on behalf of a corporation, and members of the Council on any matter pending or scheduled for Council consideration.
- h) The Technical Advisory Council shall review the submissions and any testimony presented and determine whether drug products comply with criteria in Sections 790.60 and 790.65 of this Part.
 - 1) Decisions of the Technical Advisory Council shall be by vote of the majority of members in attendance following a motion of one member which is seconded by another member.
 - 2) Any motion by one member which is not seconded by another member shall not be voted upon.
 - 3) Any motion for which tie votes are recorded shall be deemed a failed motion.
 - i) Decisions of the Technical Advisory Council concerning inclusion and exclusion of drug products to the Illinois Formulary shall be forwarded to the Director as recommendations for action by the Director.

Section 790.50 Director's Decisions as Final Orders EMERGENCY

The Director, upon review of the Technical Advisory Council deliberations and recommendations, shall determine whether a drug product shall be included in the Illinois Formulary. Such determinations shall be considered administrative decisions subject to the Administrative Review Law (Ill. Rev. Stat. 1991, ch. 110 par. 3-101) [735 ILCS 5].

Section 790.60 Bioequivalence Criteria EMERGENCY

The Illinois Formulary provides for the interchange of bioequivalent drug products which can be expected to have the same clinical effect when administered to patients under the conditions specified in the labeling. Such drug products shall meet the following criteria:

- a) Such products shall be pharmaceutically equivalent or otherwise determined to be interchangeable drug products by the Technical Advisory Council in that they:
 - 1) contain identical amounts (within 1% of the labeled amount) of the same active drug moiety;
 - 2) are comparable dosage forms;

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- 3) have the same route of administration;
- 4) are bioequivalent in that they:
 - A) do not present a known or potential bioequivalence problem, and meet an acceptable *in vitro* standard, or;
 - B) if they do present a known or potential problem, they are shown to meet an appropriate bioequivalence standard.
- 5) bear adequate labeling as specified by the FDA or USP-NF;
- 6) are manufactured in compliance with federal Current Good Manufacturing Practice regulations, as specified by Section 21(f) of the Act.
- b) A test drug product and reference drug product intended for systemic effect shall be considered bioequivalent when:
 - 1) the rate and extent of absorption of the test drug do not show a clinically significant difference from the rate and extent of absorption of the reference drug when administered at the same molar dose of the therapeutic moiety under similar experimental conditions either in a single dose or multiple doses, or;
 - 2) the extent of absorption of the test drug does not show a significant difference from the extent of absorption of the reference drug when administered at the same molar dose of the therapeutic moiety under similar experimental conditions in either a single dose or multiple doses and the difference from the reference drug in the rate of absorption of the drug is intentional, is reflected in its labeling, is not essential to the attainment of effective body drug concentrations on chronic use, and is considered medically insignificant for the drug.
- c) Bioequivalence may be demonstrated using an *in vitro* bioequivalence standard when such an *in vitro* test has been correlated with human *in vivo* bioavailability data or in other situations through comparative clinical studies or pharmacodynamic studies.

Section 790.65 Statistical Criteria
EMERGENCY

The standard bioequivalence study is conducted in a crossover fashion in a small number of volunteers, usually with 12 to 24 healthy normal volunteers. Single doses of the test and reference drugs are administered and blood or plasma levels of the drug are measured over time. Characteristics of these concentration-time curves, such as the area under the curve (AUC) and the peak blood or plasma concentration (C_{max}) are examined by statistical procedures.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF EMERGENCY RULES

- a) Bioequivalence of different formulations of the same drug substance involves equivalence with respect to the rate and extent of drug absorption. Two formulations whose rate and extent of absorption differ by 20% or less are generally considered bioequivalent.
 - 1) In order to verify, for a particular pharmacokinetic parameter, that the plus or minus 20% rule is satisfied, two one-sided statistical tests are carried out using the data from the bioequivalence study. One test is used to verify that the average response for the generic product is no more than 20% below that for the innovator product; the other test is used to verify that the average response for the generic product is no more than 20% above that for the innovator product. The two one-sided tests are carried out at the 0.05 level of significance.
 - 2) Computationally, the two one-sided tests are carried out by computing at a 90% confidence interval. The generic manufacturer must show that a 90% confidence interval of the difference between the mean response (usually AUC and C_{max} of its product and that of the innovator) is within the limits of plus or minus 20% of the innovator mean.
 - 3) The results of a bioequivalence study must usually be acceptable for more than one pharmacokinetic parameter.
- b) The Council shall consider variations from the above statistical analyses when the methods utilized produce evidence of bioequivalence at the 0.05 level of significance.

Section 790.80 Deletion of Drug Products
EMERGENCY

- a) The Director may delete any drug product from the Illinois Formulary at any time upon determination that
 - 1) Such product is not available for dispensing; or
 - 2) Such product is not available from more than one source; or
 - 3) Such product does not possess the appropriate or required approval of the FDA; or
 - 4) Such action is necessary to protect the health and safety of the public.
- b) Deletion of drug products from the Illinois Formulary may be made by the Director without prior consideration of deletion by the Technical Advisory Council.
- c) Deletions shall be noted in the Illinois Formulary.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF EMERGENCY RULES

- d) Deletions made based upon subsection (a)(3) or (4) of this Section shall be the subject of special notice to all recipients of the Illinois Formulary. Special notice may be effected by mail, electronic communication, publication, or other means deemed appropriate by the Director to provide effective and appropriate notice of such deletion prior to publication of the next edition of the Illinois Formulary.
- e) Decisions of the Director to delete drug products from the Illinois Formulary shall be considered administrative decisions subject to the Administrative Review Law [735 ILCS 5/3-101].

DEPARTMENT OF COMMERCE AND COMMUNITY AFFAIRS

NOTICE OF REGULATORY FLEXIBILITY IMPACT ANALYSIS

RULES PROMULGATED BY STATE AGENCIES THAT MAY IMPACT SMALL BUSINESS

Name Of Agency: Department of Children and Family Services

Heading of the Part: Licensing Standards for Day Care Homes

Code Citation: 89 Ill. Adm. Code 406

Sections Involved: 406.8, 406.9, 406.13

Notice of Proposal Published in Illinois Register: February 25, 1994
18 Ill Reg 2683

Statutory Authority: Child Care Act of 1969 (225 ILCS 10/1 and 10/7)

Information concerning this Regulatory Flexibility Impact Analysis shall be directed to:

Name: Linda D. Brand
Address: Department of Commerce and Community Affairs
620 E. Adams, Springfield, IL 62701
Telephone: (217) 785-6354

Other pertinent information regarding these rules: Hearings on these proposed rules will be held 7-9 p.m.:

March 21, 1994 Quality Inn One South Halsted Chicago, Illinois (312) 829-5000	March 24, 1994 Holiday Inn Highway 57 and Route 13 Marion, Illinois (618) 997-2326	March 28, 1994 State House Room 212 Springfield, Illinois (217) 782-2099
March 29, 1994 Days Inn 200 Maine Street Quincy, Illinois (217) 223-6610	March 30, 1994 Illini Room 1505 N. Neal Street Champaign, Illinois (217) 359-1601	March 31, 1994 Sweden House 4605 East State Street Rockford, Illinois (815) 398-4130

After initial scrutiny, the Department of Commerce and Community Affairs has determined that the above proposed rule may impact small businesses. Publication of this notice serves to both provide the general public with information regarding specifics of the propose rule, on request as well as elicit comments from interested parties. All comments will be considered as the analysis is formulated.

DEPARTMENT OF COMMERCE AND COMMUNITY AFFAIRS

NOTICE OF REGULATORY FLEXIBILITY IMPACT ANALYSIS

RULES PROMULGATED BY STATE AGENCIES THAT MAY IMPACT SMALL BUSINESS

Name Of Agency: Department of Children and Family Services

Heading of the Part: Licensing Standards for Group Day Care Homes

Code Citation: 89 Ill. Adm. Code 408

Sections Involved: 408.60, 408.65, 408.70

Notice of Proposal Published in Illinois Register: February 25, 1994
18 Ill. Reg. 2700

Statutory Authority: Child Care Act of 1969 (225 ILCS 10/1 and 10/7)

Information concerning this Regulatory Flexibility Impact Analysis shall be directed to:

Name: Linda D. Brand
Address: Department of Commerce and Community Affairs
620 E. Adams, Springfield, IL 62701
Telephone: (217) 785-6354

Other pertinent information regarding these rules: Hearings on these proposed rules will be held 7-9 p.m.:

March 21, 1994 Quality Inn One South Halsted Chicago, Illinois (312) 829-5000	March 24, 1994 Holiday Inn Highway 57 and Route 13 Marion, Illinois (618) 997-2326	March 28, 1994 State House Room 212 Springfield, Illinois (217) 782-2099
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JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

SECOND NOTICES RECEIVED

The following second notices were received by the Joint Committee on Administrative Rules during the period of February 15, 1994 through February 21, 1994, and have been scheduled for review by the Committee at its March 22, 1994 meeting. Other items not contained in this published list may also be considered. Members of the public wishing to express their views with respect to a rule should submit written comments to the Committee at the following address: Joint Committee on Administrative Rules, 700 Stratton Office Bldg., Springfield IL 62706.

Second Notice Expires	Agency and Rule	Start of First Notice	JCAR Meeting
4/7/94	Department of Conservation, White-Tailed Deer Hunting by Use of Bow and Arrow (17 Ill Adm Code 670)	12/27/93 17 Ill Reg 21907	3/22/94
4/7/94	Department of Conservation, White-Tailed Deer Hunting by Use of Firearms (17 Ill Adm Code 650)	12/27/93 17 Ill Reg 21927	3/22/94
4/7/94	Department of Conservation, White-Tailed Deer Hunting Season by Use of Muzzle-loading Rifles (17 Ill Adm Code 660)	12/27/93 17 Ill Reg 21952	3/22/94
4/7/94	Department of Nuclear Safety, Use of Radionuclides in the Healing Arts (32 Ill Adm Code 335)	11/29/93 17 Ill Reg 20122	3/22/94
4/7/94	Department of Nuclear Safety, Radiation Safety Requirements for Industrial Radiographic Operations (32 Ill Adm Code 350)	8/27/93 17 Ill Reg 13882	3/22/94
4/8/94	Pollution Control Board, Major Stationary Sources Construction and Modification (35 Ill Adm Code 203)	10/29/93 17 Ill Reg 18754	3/22/94
4/8/94	Illinois Emergency Management Agency, Recall of Local Emergency Services and Disaster Agencies Establishment, Jurisdiction and Accreditation (29 Ill Adm Code 300)	8/27/93 17 Ill Reg 13865	3/22/94

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLYSECOND NOTICES RECEIVED
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<u>Second Notice Expires</u>	<u>Agency and Rule</u>	<u>Start of First Notice</u>	<u>JCAR Meeting</u>
4/8/94	<u>Illinois Emergency Management Agency, Recall of Workers' Compensation Coverage (29 Ill Adm Code 510)</u>	8/27/93 17 Ill Reg 13875	3/22/94
4/8/94	<u>Illinois Emergency Management Agency, Emergency Management Assistance Program (29 Ill Adm Code 1310)</u>	8/27/93 17 Ill Reg 13843	3/22/94
4/8/94	<u>Department of Professional Regulation, Illinois Professional Land Surveyor Act of 1989 (68 Ill Adm Code 1270)</u>	9/10/93 17 Ill Reg 14550	3/22/94
4/10/94	<u>Department of Insurance, Prior Notification of Dividends on Common Stock and Other Distributions (50 Ill Adm Code 855)</u>	12/17/93 17 Ill Reg 21264	3/22/94
4/10/94	<u>Department of Conservation, Commercial Fishing in Lake Michigan (17 Ill Adm Code 850)</u>	12/31/93 17 Ill Reg 22123	3/22/94

PROCLAMATION

94-055
BREASTFEEDING PROMOTION MONTH

Whereas, during the month of May, the Illinois Department of Public Health, in coordination with Regional Breastfeeding Task Forces, public and private organizations, physicians, and hospitals throughout Illinois, is promoting the importance of breastfeeding; and

Whereas, this observance reminds Illinoisans that breastfeeding is nutritionally the best choice for infant feeding; and

Whereas, one of the Surgeon General's Health Year 2000 Health Promotion/Disease Prevention Objectives for the nation is to increase the percentage of women who breastfeed their babies at birth to 75 percent and to increase the number of mothers who have continued breastfeeding five to six months later to 50 percent; and

Whereas, only 27.9 percent of Illinois mothers choose to breastfeed their infants at birth and only 10.3 percent of Illinois mothers have continued breastfeeding five to six months later--percentages that are well below the national averages and the Surgeon General's Breastfeeding Objective for the nation; and

Whereas, increased evidence links education, determination, and support to the success of breastfeeding;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim May 1994 as BREASTFEEDING PROMOTION MONTH in Illinois and urge our communities to offer breastfeeding education and support to assure parents the opportunity of making informed choices about feeding their infants.

Issued by the Governor February 17, 1994.
Filed with the Secretary of State February 24, 1994.

94-056
HERMAN M. FINCH DAY

Whereas, the Chicago Hospital College was founded in 1912, was renamed The Chicago Medical School in 1915, and received full accreditation of the American Medical Association and the Association of American Medical Colleges in 1948; and

Whereas, in 1976, the University of Health Science was created by Herman M. Finch, chairman of the Board of Trustees of The Chicago Medical School, in response to President Johnson's National Advisory Commission on Health Manpower which called for voluntary acceptance of responsibility among the field of medical professionals; and

Whereas, the University has attained nationally and

internationally renowned faculty members under the leadership of Herman M. Finch and added the Basic Sciences and Administration Building, a clinical campus and the Heather Margaret Bligh Cancer Research Laboratories; and

Whereas, the University became the first school of higher education to rename itself in honor of a current chairman of the Board of Trustees and CEO at the request of the faculty; and

Whereas, the University was renamed The University of Health Sciences/The Chicago Medical School in honor of Herman M. Finch in January 1994; and

Whereas, Herman M. Finch has dedicated more than 45 years of service to the University and has made it a leader in American medical education, and is highly regarded among its board of trustees, faculty, alumni, students and administration;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim February 23, 1994, as HERMAN M. FINCH DAY in Illinois.

Issued by the Governor February 18, 1994.

Filed with the Secretary of State February 24, 1994.

94-057

MUSIC EDUCATION DAY AT THE CAPITOL

Whereas, the music curriculum in the schools of Illinois is designed to bring about recognition of the vital role music plays in the educational process; and

Whereas, music is a powerful and aesthetic force that presents our young people a sense of civilization by merging intellect and emotion in the search for a humane way of life; and

Whereas, music is a basic influence in the lives of millions of people who participate in experiences developed through music in the schools; and

Whereas, Music Education Day at the state's Capitol is a special opportunity for citizens to understand and support the ongoing process of music education; and

Whereas, it is important to recognize music in our schools as an essential part of the learning process and encourage and support this basic art form in the curriculums of the schools in Illinois;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim March 23, 1994, as MUSIC EDUCATION DAY AT THE CAPITOL in Illinois.

Issued by the Governor February 18, 1994.

Filed with the Secretary of State February 24, 1994.

94-058

CARTAMEDAS DAY

Whereas, Cartamedas--the Cartagena Medical School Alumni Association--has served Chicago as a Colombian Medical Association for the past 25 years and will celebrate its 25th anniversary March 1, 1994; and

Whereas, Cartamedas has helped meet the needs of Colombian hospitals and clinics by providing desperately needed medical equipment; and

Whereas, Cartamedas continues to support U.S. and Colombian medical students who need financial assistance to begin and complete their education through scholarship programs; and

Whereas, the association holds a biennial medical seminar in Colombia featuring distinguished medical panelists who provide new information and knowledge in the field of medicine;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim March 1, 1994, as CARTAMEDAS DAY in Illinois.

Issued by the Governor February 22, 1994.

Filed with the Secretary of State February 24, 1994.

94-059

DUPAGE SYMPHONY ORCHESTRA DAY

Whereas, in 1954 a group of DuPage County musicians saw the need for a community orchestra to provide a venue for classical music; and

Whereas, the organizers of the group sought to provide orchestral music to the growing audience in DuPage County and to encourage local musicians to share their time and talent to provide such a service; and

Whereas, the DuPage Symphony Orchestra performed its first concert December 12, 1954, at Wheaton High School, conducted by Russell Harvey who continued as conductor for 31 years, retiring in 1985; and

Whereas, Barbara Schubert, Conductor of the University of Chicago Symphony Orchestra, was appointed as Music Director and Conductor of the DuPage Orchestra in 1985; and

Whereas, the orchestra presents four subscription concerts every season, a Holiday Pops Concert in December, a Children's Concert in spring, and free concerts for the community several times each summer; and

Whereas, the orchestra Board of Directors conducts Young Artist auditions to seek out young people with a talent for music; and

Whereas, since its inception, the DuPage Symphony Orchestra has grown to a membership of more than 90 individuals representing 32 DuPage County and surrounding area communities; and

Whereas, the DuPage Symphony Orchestra celebrates its 40th anniversary this year, and in celebration will perform

Beethoven's Ninth Symphony accompanied by the Naperville Chorus and the Downers Grove Oratorio Society at its third subscription concert of the season;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim March 12, 1994, as DUPAGE SYMPHONY ORCHESTRA DAY in Illinois and congratulate the orchestra, its members, and the Board of Directors on 40 years of providing the opportunity to enjoy and become involved in music culture.

Issued by the Governor February 22, 1994.

Filed with the Secretary of State February 24, 1994.

94-060

EYE DONOR AWARENESS MONTH

Whereas, more than 40,000 adults and children in the United States benefited from corneal transplant surgery in 1993; and

Whereas, eyes that are not used for corneal transplant surgery are used for valuable research in blinding eye disease; and

Whereas, increased awareness programs through the efforts of Illinois Eye-Bank, the Chicago Ophthalmological Society Eye-Bank Committee, and Illinois hospitals are responsible for acquisition of more donor tissue than ever before;

Therefore, I, Jim Edgar, Governor of the State of Illinois proclaim March 1994 as EYE DONOR AWARENESS MONTH in Illinois.

Issued by the Governor February 22, 1994.

Filed with the Secretary of State February 24, 1994.

94-061

SOUTHERN ILLINOIS UNIVERSITY QUASQUICENTENNIAL DAY

Whereas, Southern Illinois Normal University was created by an Act of the 26th General Assembly of Illinois as the second state-supported normal school in Illinois; and

Whereas, Southern Illinois Normal University opened its doors at Normal Hall in Carbondale in 1874 to 53 students for a four-week summer seminar and went on to train thousands of elementary- and secondary-school teachers; and

Whereas, in 1947, the institution became Southern Illinois University equipped with a Board of Trustees and an expanded mission. It has since developed into a major university system offering degrees at the associate, baccalaureate, masters, doctoral, professional, and specialist levels; and

Whereas, enrollment at Southern Illinois University at Carbondale, Southern Illinois University at Edwardsville, the SIUC School of Law at Carbondale, the SIUE School of Dental Medicine at Alton, and the SIU School of Medicine at Carbondale

and Springfield has grown to a total enrollment of some 35,000 with students from every county in Illinois, every state in the Union, and 100 foreign lands; and

Whereas, the Southern Illinois University System provides top quality higher education to these students; engages in basic and applied research in a wide variety of disciplines; offers academic and professional service at the community, state, and national level; and conducts a number of significant international exchange programs with colleges and universities around the globe; and

Whereas, Southern Illinois University is celebrating its 125 Anniversary or Quasquicentennial Year, starting March 9, 1994; and

Whereas, Southern Illinois University has just cause to be proud of its achievements during the last century and a quarter and has earned the pride of the state to be graced with the resource and capability of this great institution;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim March 9, 1994, as SOUTHERN ILLINOIS UNIVERSITY QUASQUICENTENNIAL DAY in Illinois.

Issued by the Governor February 22, 1994.

Filed with the Secretary of State February 24, 1994.

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80 Ill. Adm. Code 2650 Solicitation for Charitable Payroll Deductions (A-3115)

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80 Ill. Adm. Code 250 State Universities Civil Service System (P-18453/93;A-1901)

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92 Ill. Adm. Code 1376 Accounting & Financial Record Requirements (P-8630/93;A-1914)
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74 Ill. Adm. Code 275 Transfers Between Accounts Within a Fund Held by State Treasurer (P-1664) (E-2119)

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17 Ill. Adm. Code 1010 Ill. List of Endangered & Threatened Fauna (P-16273/93;A-1134)
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ACTION CODES

A - Adopted Rule
AR - Adopted Repealer
C - Notice of Corrections
CC - Codification Changes
E - Emergency Rule
ER - Emergency Repealer
M - Modification to meet JCAR objections
O - JCAR Statement of Objections
RQ - Request for Correction
EC - Expedited Corrections
P - Proposed Rule
PF - Prohibited Filing Order by JCAR*
PP - Peremptory or Court Ordered Rules
PR - Proposed Repealer
R - Refusal to meet JCAR Objection
RC - Statement of Recommendation
S - Suspension ordered by JCAR
W - Withdrawal to meet JCAR Objections
*Joint Committee on Administrative Rules

ALL RULES ARE LISTED BY PART NUMBER AND HEADING ONLY. (FOR ACTION ON SPECIFIC SECTIONS, PLEASE REFER TO THE SECTIONS AFFECTED INDEX.) IF THERE ARE ANY QUESTIONS, PLEASE CONTACT THE ADMINISTRATIVE CODE DIVISION AT (217) 782-7017.

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TYPE OF RULE MAKING

am = amend to existing Section
cc = codification changes
n = New section
r = repeal of existing Section
re = reclassified
= renumbered

ACTION CODE

A = Adopted Rule
E = Emergency
P = Proposed Rule
PP = Peremptory
M = Modification
W = Withdrawal
CC = Codification Changes
RQ = Request for Correction

PF = Prohibited Filing
S = Suspension
O = JCAR Objection
F = Failure to Remedy Objections
Objection
RC = Recommendations
EC = Expedited Correction
C = Correction

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230.200	am	(P-1322/93.A-1233)	926 220	204.20	am
230.300	am	(P-1322/93.A-1233)	926 230	204.30	am
230.350	am	(P-1322/93.A-1233)	926 231	204.35	am
230.375	am	(P-1322/93.A-1233)	926 235	204.40	am
230.400	am	(P-1322/93.A-1233)	926 236	204.45	am
230.450	am	(P-1322/93.A-1233)	926 240	204.50	am
230.550	am	(P-1322/93.A-1233)	926 246	204.60	am
230.600	am	(P-1322/93.A-1233)	926 250	204.70	am
230.700	am	(P-1322/93.A-1233)	926 260	204.80	am
230.800	am	(P-1322/93.A-1233)	926 270	204.90	am
230.900	am	(P-1322/93.A-1233)	926 280	205.00	am
230.1000	am	(P-1322/93.A-1233)	926 290	205.10	am
230.Ex.A	am	(P-1322/93.A-1233)	2001	205.20	am
230.Ex.B	r	(P-1322/93.A-1233)	TITLE 8	205.30	am
230.Ex.C	r	(P-1322/93.A-1233)	230.10	205.40	am
230.Ex.D	am	(P-1322/93.A-1233)	230.20	205.50	am
230.Ex.E	am	(P-1322/93.A-1233)	40.60	205.60	am
230.Ex.F	am	(P-1322/93.A-1233)	40.80	205.70	am
230.Ex.F	am	(P-1322/93.A-1233)	40.10	205.80	am
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925.110	r	(P-525)	925 110	204.20	am
925.120	r	(P-525)	925 120	204.30	am
925.200	r	(P-525)	925 200	204.40	am
925.210	r	(P-525)	925 210	204.50	am
925.220	r	(P-525)	925 220	204.60	am
925.230	r	(P-525)	925 230	204.70	am
925.240	r	(P-525)	925 240	204.80	am
925.250	r	(P-525)	925 250	204.90	am
925.260	r	(P-525)	925 260	205.00	am
925.270	r	(P-525)	925 270	205.10	am
925.280	r	(P-525)	925 280	205.20	am
925.290	r	(P-525)	925 290	205.30	am
925.300	r	(P-525)	925 300	205.40	am
925.310	r	(P-525)	925 310	205.50	am
925.320	r	(P-525)	925 320	205.60	am
925.330	r	(P-525)	925 330	205.70	am
925.340	r	(P-525)	925 340	205.80	am
925.350	r	(P-525)	925 350	205.90	am
925.360	r	(P-525)	925 360	206.00	am
925.370	r	(P-525)	925 370	206.10	am
925.380	r	(P-525)	925 380	206.20	am
925.390	r	(P-525)	925 390	206.30	am
925.400	r	(P-525)	925 400	206.40	am
925.410	r	(P-525)	925 410	206.50	am
925.420	r	(P-525)	925 420	206.60	am
925.430	r	(P-525)	925 430	206.70	am
925.440	r	(P-525)	925 440	206.80	am
925.450	r	(P-525)	925 450	206.90	am
925.460	r	(P-525)	925 460	207.00	am
925.470	r	(P-525)	925 470	207.10	am
925.480	r	(P-525)	925 480	207.20	am
925.490	r	(P-525)	925 490	207.30	am
925.500	r	(P-525)	925 500	207.40	am
925.510	r	(P-525)	925 510	207.50	am
925.520	r	(P-525)	925 520	207.60	am
925.530	r	(P-525)	925 530	207.70	am
925.540	r	(P-525)	925 540	207.80	am
925.550	r	(P-525)	925 550	207.90	am
925.560	r	(P-525)	925 560	208.00	am
925.570	r	(P-525)	925 570	208.10	am
925.580	r	(P-525)	925 580	208.20	am
925.590	r	(P-525)	925 590	208.30	am
925.600	r	(P-525)	925 600	208.40	am
925.610	r	(P-525)	925 610	208.50	am
925.620	r	(P-525)	925 620	208.60	am
925.630	r	(P-525)	925 630	208.70	am
925.640	r	(P-525)	925 640	208.80	am
925.650	r	(P-525)	925 650	208.90	am
925.660	r	(P-525)	925 660	209.00	am
925.670	r	(P-525)	925 670	209.10	am
925.680	r	(P-525)	925 680	209.20	am
925.690	r	(P-525)	925 690	209.30	am
925.700	r	(P-525)	925 700	209.40	am
925.710	r	(P-525)	925 710	209.50	am
925.720	r	(P-525)	925 720	209.60	am
925.730	r	(P-525)	925 730	209.70	am
925.740	r	(P-525)	925 740	209.80	am
925.750	r	(P-525)	925 750	209.90	am
925.760	r	(P-525)	925 760	210.00	am
925.770	r	(P-525)	925 770	210.10	am
925.780	r	(P-525)	925 780	210.20	am
925.790	r	(P-525)	925 790	210.30	am
925.800	r	(P-525)	925 800	210.40	am
925.810	r	(P-525)	925 810	210.50	am
925.820	r	(P-525)	925 820	210.60	am
925.830	r	(P-525)	925 830	210.70	am
925.840	r	(P-525)	925 840	210.80	am
925.850	r	(P-525)	925 850	210.90	am
925.860	r	(P-525)	925 860	211.00	am
925.870	r	(P-525)	925 870	211.10	am
925.880	r	(P-525)	925 880	211.20	am
925.890	r	(P-525)	925 890	211.30	am
925.900	r	(P-525)	925 900	211.40	am
925.910	r	(P-525)	925 910	211.50	am
925.920	r	(P-525)	925 920	211.60	am
925.930	r	(P-525)	925 930	211.70	am
925.940	r	(P-525)	925 940	211.80	am
925.950	r	(P-525)	925 950	211.90	am
925.960	r	(P-525)	925 960	212.00	am
925.970	r	(P-525)	925 970	212.10	am
925.980	r	(P-525)	925 980	212.20	am
925.990	r	(P-525)	925 990	212.30	am
926.000	r	(P-525)	926 000	212.40	am
926.010	r	(P-525)	926 010	212.50	am
926.020	r	(P-525)	926 020	212.60	am
926.030	r	(P-525)	926 030	212.70	am
926.040	r	(P-525)	926 040	212.80	am
926.050	r	(P-525)	926 050	212.90	am
926.060	r	(P-525)	926 060	213.00	am
926.070	r	(P-525)	926 070	213.10	am
926.080	r	(P-525)	926 080	213.20	am
926.090	r	(P-525)	926 090	213.30	am
926.100	r	(P-525)	926 100	213.40	am
926.110	r	(P-525)	926 110	213.50	am
926.120	r	(P-525)	926 120	213.60	am
926.130	r	(P-525)	926 130	213.70	am
926.140	r	(P-525)	926 140	213.80	am
926.150	r	(P-525)	926 150	213.90	am
926.160	r	(P-525)	926 160	214.00	am
926.170	r	(P-525)	926 170	214.10	am
926.180	r	(P-525)	926 180	214.20	am
926.190	r	(P-525)	926 190	214.30	am
926.200	r	(P-525)	926 200	214.40	am
926.210	r	(P-525)	926 210	214.50	am
926.220	r	(P-525)	926 220	214.60	am
926.230	r	(P-525)	926 230	214.70	am
926.240	r	(P-525)	926 240	214.80	am
926.250	r	(P-525)	926 250	214.90	am
926.260	r	(P-525)	926 260	215.00	am
926.270	r	(P-525)	926 270	215.10	am
926.280	r	(P-525)	926 280	215.20	am
926.290	r	(P-525)	926 290	215.30	am
926.300	r	(P-525)	926 300	215.40	am
926.310	r	(P-525)	926 310	215.50	am
926.320	r	(P-525)	926 320	215.60	am
926.330	r	(P-525)	926 330	215.70	am
926.340	r	(P-525)	926 340	215.80	am
926.350	r	(P-525)	926 350	215.90	am
926.360	r	(P-525)	926 360	216.00	am
926.370	r	(P-525)	926 370	216.10	am
926.380	r	(P-525)	926 380	216.20	am
926.390	r	(P-525)	926 390	216.30	am
926.400	r	(P-525)	926 400	216.40	am
926.410	r	(P-525)	926 410	216.50	am
926.420	r	(P-525)	926 420	216.60	am
926.430	r	(P-525)	926 430	216.70	am
926.440	r	(P-525)	926 440	216.80	am
926.450	r	(P-525)	926 450	216.90	am
926.460	r	(P-525)	926 460	217.00	am
926.470	r	(P-525)	926 470	217.10	am
926.480	r	(P-525)	926 480	217.20	am
926.490	r	(P-525)	926 490	217.30	am
926.500	r	(P-525)	926 500	217.40	am
926.510	r	(P-525)	926 510	217.50	am
926.520	r	(P-525)	926 520	217.60	am
926.530	r	(P-525)	926 530	217.70	am
926.540	r	(P-525)	926 540	217.80	am
926.550	r	(P-525)	926 550	217.90	am
926.560	r	(P-525)	926 560	218.00	am
926.570	r	(P-525)	926 570	218.10	am
926.580	r	(P-525)	926 580	218.20	am
926.590	r	(P-525)	926 590	218.30	am
926.600	r	(P-525)	926 600	218.40	am
926.610	r	(P-525)	926 610	218.50	am
926.620	r	(P-525)	926 620	218.60	am
926.630	r	(P-525)	926 630	218.70	am
926.640	r	(P-525)	926 640	218.80	am
926.650	r	(P-525)	926 650	218.90	am
926.660	r	(P-525)	926 660	219.00	am
926.670	r	(P-525)	926 670	219.10	am
926.680	r	(P-525)	926 680	219.20	am
926.690	r	(P-525)	926 690	219.30	am
926.700	r	(P-525)	926 700	219.40	am
926.710	r	(P-525)	926 710	219.50	am
926.720	r	(P-525)	926 720	219.60	am
926.730	r	(P-525)	926 730	219.70	am
926.740	r	(P-525)	926 740	219.80	am
926.750	r	(P-525)	926 750	219.90	am
926.760	r	(P-525)	926 760	220.00	am
926.770	r	(P-525)	926 770	220.10	am
926.780	r	(P-525)	926 780	220.20	am
926.790	r	(P-525)	926 790	220.30	am
926.800	r	(P-525)	926 800	220.40	am
926.810	r	(P-525)	926 810	220.50	am
926.820	r	(P-525)	926 820	220.60	am
926.830	r	(P-525)	926 830	220.70	am
926.840	r	(P-525)	926 840	220.80	am
926.850	r	(P-525)	926 850	220.90	am
926.860	r	(P-525)	926 860	221.00	am
926.870	r	(P-525)	926 870	221.10	am
926.880	r	(P-525)	926 880	221.20	am
926.890	r	(P-525)	926 890	221.30	am
926.900	r	(P-525)	926 900	221.40	am
926.910	r	(P-525)	926 910	221.50	am
926.920	r	(P-525)	926 920	221.60	am
926.930	r	(P-525)	926 930	221.70	am
926.940	r	(P-525)	926 940	221.80	am
926.950	r	(P-525)	926 950	221.90	am
926.960	r	(P-525)	926 960	222.00	am
926.970	r	(P-525)			

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